

**The Psychoanalytic Study
of the Child**

VOLUME VII

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THE MUTUAL INFLUENCES IN THE DEVELOPMENT OF EGO AND ID

By HEINZ HARTMANN, M D (New York)

I cannot say that I feel too much at ease in introducing this symposium on *The Mutual Influences in the Development of Ego and Id*. There is in analysis hardly a topic that is more comprehensive. Whatever I could tell you would hardly add up to an integrated picture. The time allotted would not even suffice for a catalogue of the problems involved. But I do hope that this very difficulty, of which you are no doubt as well aware as I am, will prevent you from accusing me of any sins of omission, and that you will extend to me the privilege of a personal approach: the right to accentuate freely and, above all, to select for my presentation only certain aspects of our problem, while discarding many others though they may be of equal importance for an integrated psychoanalytic theory of development.

I shall submit to you for discussion some possible avenues of approach, trying to place the problem, as it were, make a few suggestions for clarifying, evolving and integrating some of its aspects and will start, as is customary, with some historical remarks, which however, I shall try to limit to a minimum.

The concept of an ego you find already in Freud's (1950) physiological psychology of 1895 and in some clinical papers dating from the same period. These first formulations were followed by years of great discoveries: the psychological foundation of analysis in *The Interpretation of Dreams*, the libido theory, the insight into the etiology of neurosis, the genetic turn—that is, the discovery of the decisive relevance of early life history, and the development of psychoanalytic technique. During these years the role of the ego is little emphasized and at times even completely submerged under the impact of the theory of instincts. Only in the twenties was ego psychology explicitly defined as a legitimate chapter of analysis. The ego evolves as one system of personality, clearly set apart from the functions of the id and of the superego. This renaissance of the ego concept encompasses Freud's insights into the unconscious and the instinctual drives, the disregard of which had been a deadly limitation of the

usefulness of other, preanalytic concepts of the ego. Freud outlined an ego which is infinitely richer in importance, dimensions, and specificity of functions, in comparison with his earlier formulations. On this later level Freud's ego concept, though elements of early formulations have been integrated, appears as something essentially new, also as to its effects, because of the revolutionizing impact it had on the development of many aspects of psychoanalysis, including the theory of instinctual drives. This development, by the way, always struck me as one rather clear-cut example for a tenet of the philosophy of Hegel, who saw the evolution of concepts in terms of thesis, antithesis and synthesis.

To approach more closely the ego-id problems under discussion today, we may say that this growing in stature of the ego's role in Freud's thinking can be seen: structurally, in its description as a partly independent unit of personality; dynamically, in Freud's warnings against a simplifying generalization he had noticed in the work of some analysts, which tended to underrate the ego's strength vis-à-vis the id (see also A. Freud, 1936); economically, in the hypothesis of its being fed by a mode of energy different from that of the drives. The independent aspect of the ego is even more conspicuously stressed in one of Freud's later propositions, suggesting the hereditary nature of some of its elements.

In developing his ideas on ego-id relationship, Freud followed the lead of technical and clinical as well as theoretical insights. The interest in these problems extends from technological detail to the most abstract level of theory formation. However, we should not forget that the aspects of the ego we see, viewing it from the angle of resistances, are not necessarily the same as those which are in the foreground in the study of, let us say, psychosis, and neither the one nor the other of these groups of aspects will fully coincide with that part of the ego which becomes visible in the direct observation of children. Thus, partial ego concepts developed which Freud succeeded in integrating in his more general propositions. Different facets of Freud's thinking on ego and id have been worked out by different analysts in different directions. Besides the nature of the data used, theoretical preferences have an obvious influence on an analyst's centering his research on one rather than on another of these partial concepts of the ego. To emphasize only one partial concept of the ego, at the expense of other aspects, may be a question of expediency vis-à-vis specific problems. But we shall remember that the reality ego, the defensive ego, the organizing, the rational, the social ego; the ego that leads a shadowy existence between the great powers, the id and the superego; the ego evolving under the pressure of anxiety situations, are not "the ego" in the sense of analytic psychology. These are partial concepts to be distinguished from Freud's general ego concept.

Freud knew that the reliability of our statements and particularly of our predictions depends, in analysis, as in other sciences, among other things, on how comprehensive and consistent a general theory has been developed. He wanted to get insight "into the entirety of mental functions," as he wrote very early. That is, he aimed, as he repeatedly said, beyond his clinical research at what one could call general psychology, encompassing normal phenomena as well as pathological ones. This has remained one trend in his work through all the years. Its outline in Freud's work is considerably more comprehensive than what has yet been systematically elaborated in psychoanalysis. He often said that his not yet having dealt with some problem did not imply his negating its relevance.

I mention this here because what we are to discuss today is actually one aspect—perhaps the most important one in the present situation of analysis—of such an analytical approach to general psychology. It obviously transcends a narrower concept of analysis that would limit it to the understanding and therapy of neurosis. It aims at normal as well as pathological development. Secondly, the dealing with these developmental problems also often transcends what is directly accessible to the psychoanalytic method. I am speaking of the child's growth and development up to the end of the preverbal stage. Still, this trend in analytic research is relevant also for a better understanding of clinical and technical problems, and it will become important particularly in regard to questions of mental prophylaxis.

Guarded extrapolations from what we know about later stages of development to earlier stages are widely used in the genetic hypotheses of psychoanalysis. It is amazing how much analytical reconstruction has taught us even about those primordial stages. Still, a host of questions as to the relative relevance of our various constructs, about the chronology in the development of different functions, and so on, remain controversial. In this situation the most auspicious development is the recent introduction into analytic child psychology of direct observation of the growing infant and child by analysts or at least analytically trained observers (see A. Freud and others). This can be helpful in checking our genetic hypotheses against observational data; and it can be decisive in giving us positive clues for the formation of hypotheses. We can learn from the correlation of reconstructive data with data of direct child observation how the latter can be used as indicators of structurally central developments, etc. This trend has already given our knowledge of early ego-id development an incomparably greater concreteness, especially as to its reality aspects. Here, then, not only the "negative" aspect of the ego, its role as adversary of the drives, but also many other specific ego

functions and their interrelatedness become of necessity a legitimate concern of the analyst. This is a decisive step toward a general analytic theory of motivation.

It has also become apparent, I think, that to speak of the ego in a summarizing way as, let us say, threatened by the id or helpless vis-à-vis the id, as is often done, is no longer a sufficient description of developmental reality even in those early stages. It is not always advisable to conceive of these relations between ego and id as if they were just two opposing camps (Freud, 1926). The object of research is the great variety of developing ego functions, in their antagonistic but often also synergistic interdependence with the id, and their differential consideration (intrasystemic approach; Hartmann, 1951).

In speaking of the mutual influences in the development of ego and id, we are used to considering the former, more often, the dependent, the latter, more often, the independent variable. We are impressed by the flexibility, by the learning capacities of at least parts of the ego, and, on the other hand, by the stubborn opposition to change of the instinctual drives. Still, there are those changes in the id that are brought about by the growth or development of the instinctual drives through all their subsequent phases; also, the ego can take a measure of influence by draining the instinctual energies of the id or damming them up; there are those modifications that, via the ego, analysis can induce in the id; there is, although it may not be fully understood yet, the id aspect of the outcome of repression (see also E. Bibring, 1937). Freud (1926) felt that his originally general assumption that repressed impulses remain unchanged in the id might be in need of revision. This might not be the only possible outcome of repression. Two cases would have to be considered: "mere repression and the true disappearance of an old desire or impulse." Repressed instinctual tendencies may lose their cathexes, which could then be used in different ways. In the case of the breakdown of the oedipus complex, according to Freud, they are sublimated and used in the resulting identifications. In other cases one may think of a kind of displacement of these energies that might help to promote the next step in instinctual development, an important proposition which has been suggested by A. Katan-Angel (1951).

The strength of the ego in its relationships with the id lies in finding ways that make discharge possible; or, in other cases, in imposing changes of aims, or of the modes of energy involved; in the capacity to build counter-cathexes; in its control of perception and motility, and in its use of the danger signal and access to the pleasure-unpleasure principle. One aspect of ego development can be described as following, in several re-

spects, the lead of the drives. We are used to speaking of an oral and anal ego, and so on, and trace specific ego attitudes to specific libidinal characteristics of the correlated phase. This aspect shows the phases of ego development in close connection with the sequence of libidinal phases. However, while rich clinical material and also data of direct observation testify to the importance of this relation, the ways in which ego attitudes are formed by the characteristics of the libidinal phase are not always clear. I think that in some cases the characteristics both of the instinctual tendencies and of the attitudes of the ego may have a common origin in the undifferentiated phase. Of giving, getting, etc., we can assume that they are modeled after instinctual patterns. A partial modeling after instinctual patterns we may also assume in the case of some defense mechanisms, as for instance in identification and projection (Hartmann, 1939a). But to describe ego formation only in terms of its dependence on instinctual development is to give only part of the picture. This is only one of its facets, among several, a point to which I shall return in more detail later. While describing the development of the child in terms of libidinal phases, we are today very much aware of the fact that cross sections of development cannot be completely described in referring only to libidinal aims—not even if we include the corresponding object relationships in our description. We have to describe them also with respect to the involvement of two other series of factors: the vicissitudes of aggressive drives and the partly independent elements in the ego. It might well be that even the timing and the individual formation of the typical phases could to some extent be traced to individual variations of ego development, e.g., to the precocity of certain of its functions which might become relevant also for pathology (Hartmann, 1950b).

Some aspects of earliest ego-id interrelations could be partly clarified through the study of regressive phenomena in psychosis¹ and also for instance, of the phenomena occurring during the process of falling asleep (Isakower, 1938). For the understanding of the same problems in some instances and of different ones in others the approach through the study of the body ego and of object relations has proved essential. The body being the mediator between the inner and outer world and what we call objects being the emotionally most relevant representatives of the latter the approach through the body ego and the object relations is also the preferred access to studying how ego-id relations develop in the individual's interaction with the environment. The development of the body

¹ I may add that today as one consequence of progress in analytic child psychology a clarification also in the opposite direction from the knowledge about in fancy and early childhood to a better understanding of psychosis seems to be well under way.

ego will be discussed by Hoffer.² I shall at this point say a few words about object relations, or, rather, about only a few facets of object relations that seem relevant to our discussion. Freud (1926) found that "the influence of the environment is intensified, the differentiation of the ego from the id is promoted very early, the dangers which the environment presents are increased in importance, and the value attached to the object who alone can offer protection against these dangers . . . is enormously augmented," as a consequence of the protracted helplessness and dependence of the human child. We may also say that in the human the pleasure principle being a frequently unreliable guide to self preservation, and the id, as Freud once said, neglecting it, the development of a specific organ of learning and adaptation, the ego, has become of vital importance. This we could call a circular process. The ego-id differentiation complicates the relations between pleasure and preservation of the self. The id, in obvious contrast to the instincts of the animals, neglects the latter. But this very fact probably acts as a stimulus for further ego-id differentiation (Hartmann, 1948). I am emphasizing here the specifically human side of these problems, the distinction between ego-id structures of man and the instincts of lower animals, as a basis for later discussion of ego-id differentiation.

It is in approaching the problem of the child's interaction with his objects, of his indulgences and frustrations, that the study of the "reality factor" and the interest in ever more specific situations in the child's life became particularly meaningful—what Kris (1950b) called the "new consideration for the environment." On the side of theory, one aspect of this trend is clearly based on that part of Freud's reformulations which traces internal danger situations to external ones, and on the subsequent work of A. Freud and others. For the time being it is this trend in analysis, above others, which quite naturally leads to a development that was briefly mentioned before: the integration of the reconstructive data of analysis with data gained from the systematic, not merely occasional, use of direct observation of children, and to an increased concern for a more inclusive view of child development. Some of these studies, as you know, also include an investigation of the most important objects in the child's life (mostly the mother, who is studied together with the child). Thus, for instance, the relevance of the mother's conflicts in the shaping of the child's attitudes and defenses can sometimes be traced (E. Jackson and E. Klatskin, 1950).

Such newer studies show in detail the participation of instinctual and ego tendencies in the development of the child's object relations. What

² See this volume, pp. 31-41.

we call "satisfactory object relations" has an id but obviously also an ego aspect. In recent years the impact of incomplete or empty relationships with the mother on ego development has been emphasized repeatedly (Durfee Wolf, 1933, Ribble, 1943, Spitz, 1945, and others). While these findings are valuable and no doubt valid, the danger of overemphasizing and oversimplifying this side has not always been avoided. The fact that the mother has "rejected" her child in one way or another is frequently, in unilinear causal relation and rather indiscriminately, made responsible for nearly all varieties of later pathological developments and particularly of ego disturbances. That the ego needs, in order properly to function and to develop, a secure relation not only to the drives but also to the objects, is obviously true. But ego development and object relationships are correlated in more complex ways than some recent works would let us believe—which we could already expect on theoretical grounds. We do not know much about corrections of very early unsatisfactory situations through later maturational processes.³ It might also be that not only can "poor" early object relations be sometimes made up for by later ego development, but also that so called "good" object relations may become a developmental handicap—probably, I should think, if and in so far as the child has not succeeded in utilizing them for the strengthening of his ego. Also there is a long way from the object that exists only as long as it is need satisfying to that form of satisfactory object relations that includes object constancy. The work done by A. Freud and her co-workers has an immediate bearing on this subject. This constancy probably presupposes on the side of the ego a certain degree of neutralization of aggressive as well as libidinous energy (a concept we shall discuss later) and on the other hand it might well be that it promotes neutralization.⁴ That is, "satisfactory object relation" can only be assessed if we also consider what it means in terms of ego development.

Of all the manifold relationships between ego and id, the one of conflict, the one in which the instinctual drives come to be considered as a danger—in which case the anxiety signal induces defense of the ego—is the one by far most familiar in analysis. It is the one most immediately relevant for our clinical work and at the same time, because of specific features of our technique, the one best accessible to our method. Thus most of our clinical knowledge on the interaction of ego and id we owe to the study of conflict.

³ See however Lois Murphy (1944) also Beres and Obers (1950) and now the important paper by A. Freud and S. Dann (1951).

⁴ For this second aspect see also A. Freud (1949) and E. Kris (1950b).

However, we also speak of collaboration of ego and id and in doing so seem to point to a variety of processes: The ego may serve the aims of the id; or the energy of the id is available for the aims of the ego; there may be substitution of ego aims for id aims, or neutralization of instinctual energy. The two last-mentioned processes often go together but may also vary partly independently, as is the case in sexualization.

What the methods used by the ego and its defensive actions are, and what these mechanisms mean in terms of the ego and of the id, has been stated with great precision in the classical contributions of Freud (1926), Anna Freud (1936), Nunberg (1932), and others. Freud's ideas about countercahesis brought us a metapsychological grasp of the ego aspect. This subject of fundamental significance, conflict and defense, is today among the best known chapters of analytic theory, clinic and technique—though some aspects, as for instance the chronology of defense mechanisms, still pose a number of unsolved problems.

At this point, I want to discuss only some aspects, developmentally relevant but more or less at the periphery of defense itself. It has proved useful to isolate for specific purposes the setup "defensive action—warded-off impulse." But, of course, for the developmental approach—and, for that matter, even sometimes for the clinical or technical aspects—it becomes relevant and indeed necessary also to ask how in a developmental cross section or in a longitudinal section, considering the predisposition to or the precursors (and also the aftermaths) of defense, this setup is interrelated to other functions of the ego. This is what I had in mind in speaking of the interrelation of the conflictual and nonconflictual spheres of the ego (1939a). Factors in the nonconflictual sphere codetermine the methods by which instinctual stimuli are dealt with, or, more specifically, the ways of conflict solution, and are in turn influenced by the latter. To study these processes seems particularly relevant in the early stages in which not only the use but the development of the defense mechanisms is in question.

There is a factor of another order that may have an influence on conflict, a factor whose origin also transcends the factors immediately involved in the conflict situation. I am thinking of a proposition formulated by Freud in one of his last papers; it has so far been given little attention. Freud (1937) suggests that there may exist an individually varying tendency toward conflict which, independent of the conflict situation itself, could be correlated with the presence, or the amount, of free aggression. He suggests that we might "... review all of our knowledge of physical conflicts from this new angle." I tried some time ago (1950a) to develop Freud's suggestion in a specific direction, about which I shall say a few words later.

In the context of today's discussion we may ask what the antecedents of the ego's turning against the id are. This direction of the interest of some analysts is somewhat analogous to the turning toward the preoedipal phases also, after the main aspects of the oedipal situation had been explored. In what follows, I shall merely touch on a few points of the earliest phases of this development. In the last part of my paper I shall then turn to a later phase to how some of the more remote consequences for the ego of the ways in which conflicts with the id have been dealt with can be evaluated.

Earliest stages of ego development can be described as a process of differentiation that leads to a more complete demarcation of ego and id and of self and outer reality, as a process that leads from the pleasure to the reality ego, as the development of the reality principle, as the way leading from primary narcissism to object relationships, from the point of view of the sequence of danger situations, as the development of the secondary process, etc. The important thing for a systematic study of the subject, which, as I said, is not intended here, would be to clarify the interrelatedness of all these aspects of ego development.

In the earliest postnatal stage it is difficult to disentangle the nuclei of functions that will later serve the ego from those that we shall attribute to the id. Also, it is often hard to decide what part of it could already be described in terms of mental functioning. Neither is there at that stage any differentiation of the self from the world outside. That there is no ego in the sense we use the term for later stages, seems clear, what the state of the id is at that level is unknown. This stage we may term the undifferentiated stage (Hartmann, 1939a, Hartmann, Kris and Loewenstein, 1946). This conception of the earliest postnatal stage seems to be in agreement with Freud's later thoughts. At least once, in the "Outline" (1939), he speaks of "the id, or rather, the undifferentiated ego id."

In speaking of ego-id differentiation, Freud introduces hypotheses some of which clearly follow anatomical or physiological models, and he uses not only ontogenetic but also phylogenetic hypotheses. I am not concerned here with studying the interrelation of ontogenetic and phylogenetic propositions, interesting as such an attempt might be. Also, our acceptance of phylogenetic hypotheses depends more on our adherence to this or that school of evolutionism than on our analytic experience and thinking. Anyway, in the present context it becomes important clearly to demarcate the two sets of hypotheses.

In ontogenesis the id-ego differentiation follows the leads of outer and inner perception, of motility, and of the systems of preconscious memory traces, of experience and learning. The replacement of hallu-

ination by thinking, of direct motor discharge by action, are essential elements in Freud's theory of ego development. The body in its double position as part of the inner and also of the outer world plays a decisive role in this process—above all, as Freud said, its surface, but also those stimuli that reach the mental apparatus from the inside of the body, and, in a specific way, pain. After Freud, Schilder (1938), Bychowski (1943), Scott (1948), Hoffer (1949, 1950) have helped us to get some glimpses into these many faceted developments. Hoffer's recent studies of the early connections between oral functions and the use of the hand, and of the role they play in the development of the primitive ego, have clarified one of the earliest and most consequential steps.

I shall discuss one aspect of these differentiating processes in greater detail, not necessarily because it is the one that seems most important, but because its role in ego development has not always been clearly realized. Generally speaking, the apparatus serving perception, motility, and others that underlie ego functions, seem, in the infant, to be activated by instinctual needs. Their use independent of immediate needs, and in a more differentiated relation with external stimuli, is already part of the development of the reality ego. But they are not created by the needs. These apparatus, as well as those that account for the phenomena of memory, are partly inborn, they cannot be traced, in the individual, to the influence of the instincts and of reality, and their maturation follows certain laws which are also part of our inheritance.⁵ They will gradually come under the control of the ego, on the other hand, they act on the ego and its subsequent phases of development (Hartmann, 1939a, 1950a). They can also be considered as one factor among those to which the ego-*id* differentiation can be traced. Here, then, is one of the points where phylogenetic hypotheses have to be clearly set apart from ontogenetic ones if we want to avoid misunderstandings. The differentiation of ego and *id*, developed by whatever process of evolution through hundreds of thousands of years, is, in the form of a disposition, in part an innate character in man. That is, this differentiation does not start from scratch in every newborn child.

It is tempting to view this aspect of ego development in a way analogous in principle, though not in extent, to that which we have long since accepted in accounting for the libidinal phases. In tracing their significance we are used to considering the anatomical and physiological

⁵ It is rather generally accepted in biology that part of what we call maturation is developed without the guidance of function as such and that it may have adaptive significance only in reference to its future function (Weiss 1949). However the same author adds that there is of course no rigid preadaptedness "to fit precisely one particular detailed course of life." For the difference between adaptedness and adaptation see also Hartmann (1959a).

growth processes underlying them. Freud mentions the importance of the appearance of the teeth, the development of the anal sphincters, etc. I think something similar holds good for the development of the ego—maturational processes in the motor apparatus and the interaction with specific ego functions we may consider one case in point. A detailed knowledge of the stages of development on the side of the ego will be our most valuable guide in extrapolating reconstruction—in deciding what degrees of differentiation and integration of function, what degree of mechanism formation, can be assumed to exist on a given developmental level. Again, here as elsewhere, the fact that I emphasize in this context one facet—in this case, maturation—should not be misconstrued as any underrating of the specific importance of learning processes for the development of the ego.

This consideration of maturational processes also on the side of ego development seems natural enough if we keep in mind that the ego aspect of development is no less "biological" than its id aspect. It seems hard to call nonbiological the functions of adaptation and of synthesis, or integration, or organization (that is, the centralization of functional control), both of which we attribute to the ego. In a late paper Freud (1939) even attributes to the ego, and not to the instinctual drives, the function of self-preservation in man: "The ego has set itself the task of self-preservation which the id appears to neglect." As to the physiological aspect of the problem, Freud always maintained that in some future time physiological data and concepts would be substituted for the psychological ones, referring to all mental functions and not only to those of the id. I may add that analysts as well as physiologists have, I think correctly, emphasized that it is particularly the study of the ego functions which might facilitate a meeting between the psychoanalytic and the physiological, especially the brain-physiological, approach.

In the ego's relationship with the body, we can now describe three aspects: the postulated physiological processes underlying activities of the ego; the apparatus that gradually come under the control of the ego and which in turn influence the timing, intensity, and direction of ego development; and, third, but not necessarily independent of the two others, those special structures that underlie what we call the body ego.

In his last years Freud thought that some aspects of the defense mechanisms may have a hereditary core. At the time he wrote *The Ego and the Id* he did not think that ego functions could be inherited the same way as he assumed that certain characteristics of the instinctual drives were. However, he states in "Analysis Terminable and Interminable" (1937): "We have no reason to dispute the existence and importance of primal, congenital ego-variations," and "It does not imply a mystical over-

estimation of heredity if we think it creditable that, even before the ego exists, its subsequent lines of development, tendencies and reactions are already determined." I think that these formulations of Freud's we should not fail to consider in this discussion. The role of analysis, vis-à-vis this aspect of development, can be based on what Freud (1924) once wrote in discussing hereditary versus environmental influences: "After all, it is of interest to follow up the way in which the innate schedule is worked out, the way in which accidental noxae exploit the disposition."

Those inborn characteristics of the ego, and their maturation, would, then, be a third force that acts upon ego development, besides the impact of reality and of the instinctual drives. Of the elements on the side of the ego which originated in this hereditary core, whose development is of course not independent from the development of other elements, but which enter this development as an independent variable, we may speak as of autonomous factors in ego development (primary autonomy) (Hartmann, 1939a, 1950a).

It may be that very early processes in the autonomous area—cathectic organizations, but also physiological mechanisms that develop in interdependence with them, factors like postponement of discharge and also what Freud calls the protective barrier against stimuli (see also Bergman and Escalona, 1949), and even reflectory defenses against unpleasant stimuli—are genetically speaking precursors of what at a later stage we call defense mechanisms (Hartmann, 1950a).

In summarizing this part of my presentation, may I say that certain aspects of the choice and of the chronology of defense mechanisms might become better accessible to our understanding once we possess a closer insight into the development of their precursors. From the point of view of method, I may mention that at least some of them could be approached by *direct observation*. Little is known so far about what the role of such factors might be in what has been called "primary" disturbance of the ego (see, for instance, Hendrick, 1951).

One should also try to describe all ego-id correlations with regard to their energetic aspects. We think with Freud that the ego habitually uses a mode of energy different from that used by the drives. He speaks of desexualized and also of sublimated energy. We also know that if energy serving the functions of the ego comes too close to the state of instinctual energy (sexualization), this results in a disturbance of function. It does not seem too hazardous to enlarge this idea of Freud's to include neutralization of aggressive energy (Hartmann, 1948); this has also been done by K. Menninger, 1938; Jeanne Lampl-de Groot, 1947; etc.), which may serve functions of the ego and, maybe in a somewhat different state, also

of the superego. Of the modified aggressive energy used in the ego it also seems true that if its state comes too near to the instinctual mode, this may interfere with ego function (Hartmann, 1950a). The term neutralization, used here and elsewhere, is meant to cover, besides what Freud called sublimation (which he limited to one of the vicissitudes of the libidinal drives), also the analogous change in mode of aggressive drives.

If we assume the widest possible concept of neutralization (including sublimation), we may say that, though it may serve defense, it is of a far more general nature than other processes used for defensive purposes. Neutralization in this sense may well be a more or less constant process—if we are ready to assume that all the ego functions are continuously fed by it. But it is this very character that gives it its specific importance for the understanding of ego-id relations, also outside of the sphere of conflict.⁶

Although the general energetic features of typical ego and id functions are no doubt as we are wont to see them, it seems not unlikely that there exist, looked at from this angle, transitions between instinctual and fully neutralized energy. It is probable that aggression used by the superego against the ego is closer to the instinctual condition of energy than the one used by the ego in some of its functions. Probably correlated with this aspect are the degrees to which the primary process has been replaced by the secondary process.

Neutralization of energy seems clearly to be postulated from the time at which the ego evolves as a more or less demarcated substructure of personality. And viewed from another angle, we might expect that the formation of constant object relationships presupposes some degree of neutralization. But it is not unlikely that the use of this form of energy starts much earlier and that already the primordial forms of postponement and of inhibition of discharge are fed by energy that is partly neutralized as to some of its aspects. Some counter-cathetic energy distributions arise probably in infancy. Again these and related phenomena seem easier to understand if one accepts the hypothesis of gradations of neutralization as just outlined.

A further complication is added by the fact that we know a rather wide field of phenomena that we could describe as Janus-faced in the

⁶Neutralization even where it is used for defense stands apart from other defensive techniques of the ego in so far as it is specially defined by its energetic aspect (among others), which means here by the change of one mode of energy into another one. That sublimation is not really a mechanism in the usual sense (Fenichel (1915) has clearly seen and this holds good also for neutralization in general. Also that its relation to counter-cathexis is different from the one we find in other forms of defense. However I cannot follow Fenichel when he simply equates sublimation with successful defense.

sense that one aspect shows the primary and the other the secondary process. To use Anna Freud's (1936) example, in displacement as a mechanism of defense, a characteristic of the primary process is used for the purposes of the ego. This we also clearly see in dreams. Also, processes we describe as vicissitudes of the instinctual drives may at the same time be used by the ego for its own purposes (see also Eidelberg, 1940). As for the case of displacement, we may add that in a way it also is a primordial form of learning. It widens the child's experience and is a primitive basis on which the integration and differentiation of experiences may be built. I think that M. Klein (1930) thought along similar lines in emphasizing the relevance of symbol formation for ego development.

There are many early and important developments which we have learned to consider as two-faced, that is, as to their ego and their id aspects. From the point of view of developmental psychology it becomes relevant to see whether the two aspects are co-ordinated in the way we would expect, according to our knowledge of parallel development in ego and id, on which side the functional accent—if I may say so—lies at a given stage, whether one of the aspects has outdistanced the other, etc. Cases in which the expected equilibrium between ego and id development is lacking often give us a good opportunity for insight into the psychological structure of the developmental phase in question. Sometimes, disorder in the typical sequence of danger situations may result. Precipitating or retarding factors we find both on the side of the id and of the ego. precocious ego development, for instance, may be due to specific instinctual demands (danger situations), to early identifications, to an unusually early development of the body ego, to autonomous elements etc. Here again I select for discussion only one developmental aspect of object relations. We can view them from the angle of the needs involved but they also have a cognitive side, a perceptual side, and so on. 'Object formation' has a somewhat different meaning in analytic and nonanalytic child psychology. Still I emphasized long ago that what nonanalytic psychologists have carefully described in their experimental work as the evolving of constant and independent objects in the child's world (as tested for instance in the child's handling of toys, etc.), cannot be fully understood without considering the child's object relations in our sense (see also Spitz and Wolf, 1949). One may suggest that the element of identity and constancy in what one calls "objects" in the general sense is partly traceable to the element of constancy gradually developing in what we describe as libidinal or aggressive object cathexis—though, of course, other factors too partly autonomous are involved. The child learns to recognize "things" probably only in the process of forming more

or less constant object relationships. We assume that progress in neutralization is involved in both steps, and that as to this factor both steps have a common origin. Also the development of what one calls "intentionality"—the child's capacity to direct himself toward something, to aim at something, in perception, attention, action, etc., a process that according to Freud probably presupposes hyper-cathexis—could be viewed as one ego aspect of developing object relations. Actually, intentionality is among the first achievements of the child we would not hesitate to characterize as true ego functions. Others among the especially developmentally interesting, but little explored object-directed ego tendencies should be systematically approached in the same way.

To come back to the energetic aspect: What Freud once called "the witch metapsychology" would, by any other name, be what we have to appeal to in questions of general psychoanalytic psychology. Actually today we come to considering it not so much as something "meta," beyond psychology, but just as the most general level of psychological concepts in analysis. On principle we should be able to describe all the relations we find between ego and id as to the modes of energy they use, but also in terms of cathexis. We are far from fulfilling this demand. Some aspects, after Freud, have been studied, for instance, by Glover and Rapaport. Kris (1950a) recently approached the problem of preconscious mental functions from this angle. The conscious and preconscious phenomena are characterized by the secondary process, one aspect of which is inhibition of discharge, and they are specific of the ego in contradistinction to the id. To describe the preconscious in metapsychological terms has become even more important since Freud (1939) no longer thought that another characteristic upon which he had previously relied—that is, the addition of word representations to thing representations—is typical of all the mental processes in the preconscious. Evidently, for the questions of ego-id differentiation and interrelation, it is essential to trace how the secondary process originates. Glover (1935), taking his point of departure in the earliest systems of preconscious memory traces, describes the syntheses of such psychic elements associated with drive components as nuclei of ego formations. Out of this stage an organization of memory gradually evolves which has learned to consider elements of reality. Rapaport (1950, 1951) puts particular emphasis on the assumption that involuntary delay of instinctual discharge, due to external circumstances, can later be converted into an ability to delay, that is, into internal control. This hypothesis fits in rather well with what we recognize as one characteristic of ego development: that is, the gradual active use by the ego for its own purposes of primordial forms of dealing with stimuli. Internal control is one aspect of the problem of counter-cathexis, which

Freud repeatedly tried to account for, and one fundamental aspect of ego-id differentiation. But the fundamental question, which way the original transformation of the primary energy distribution into that representing instinct control takes place, is still in need of further clarification. It might be, as I have already mentioned, that those inhibitory apparatus serving postponement of discharge, which are gradually integrated into the ego and which are probably also precursors of later defense mechanisms, play a role in the change of one mode of energy into another one. One may ask what we can say about the nature of the drive energies whose mode is being changed in the process of the formation of counter cathexis. Again, it seems hazardous at present to venture an hypothesis with respect to this aspect of the primordial or precursory steps of differentiation. For a later stage, I tried to find an answer in the synthesis of two of Freud's hypotheses—the one, mentioned above, which says that free aggression may be an important factor in the disposition to conflict, and the other, which assumes that the features of defense against instinctual drives are modeled after defense in situations of danger from without. Withdrawal of cathexis would correspond to flight, and counter cathexis to fight. On the basis of these two hypotheses we may develop the suggestion (Hartmann, 1950a) that the ego's counter cathexes against the drives are likely to be mostly fed by some shade of neutralized aggression, which nevertheless still retains some characteristics of the original drives (fight).[†] This assumption may well carry us a few steps further also in the understanding of pathological development. I think that the failure to achieve stable defenses, a failure we see in various forms of child pathology and which is also a crucial problem in schizophrenia, is to a large extent due to an impairment of the capacity to neutralize aggressive energy.[‡] This hypothesis also implies a double correlation of stable defense with constant object relations, if what I said before is true—that the development of constant object relations on the one hand facilitates, but on the other also depends on, neutralization. However, these and related implications referring to pathology I shall try to present in a more detailed and systematic way elsewhere.

This hypothesis would imply that counter cathexis may be a rather general way of utilizing aggression in one of its neutralized forms—a way different from the utilization of aggression in the service of the superego, though maybe not quite independent from it. It might well be that the aggressive superego pressure on the ego also results in the ego's utilizing aggressive energy in its dealings with the id—a kind of turning

[†] A somewhat similar proposition was formulated by M. Brierley (1947).

[‡] For another aspect of impairment of neutralization in the pathology of schizophrenia, see Hartmann (1950a).

one aggressive intersystemic relation (superego ego) into another (ego id). This may be one energetic aspect, the aspect referring to the conditions and distributions of energy, of the role of the superego in repression and of other phenomena familiar to all of us from clinical experience. However, I do not think that this dependence of aggressive ego defense on the function of the superego applies to all of its forms, and it cannot apply, of course, to the early stages of defenses.

I shall devote the last part of my paper to one aspect of ego id relationships at developmental stages at which the ego has already evolved as a definable psychic system with specific functions. It has acquired, through its prehistory, the capacity to institute and utilize some methods to avoid danger, anxiety, unpleasure. It has developed functions, such as objectivation, anticipation, thought, action, etc., and it has achieved a more or less reliable synthesis, or integration, or organization, of its own functions and of the whole of psychic personality. The very complexity of the system tends to increase its lability, as Freud has pointed out. However, we find that various functions of the ego may achieve various degrees of virtual independence from conflicts and from regressive tendencies in various individuals. What I have in mind here is the question of their reversibility or irreversibility, the question of their relative stability vis à vis inner or outer stress. Obviously many, though not all, attitudes of the ego can be traced to genetic determinants in the id, to the sphere of the instincts—or also to defensive processes. We are used to see that ego interests and other ego tendencies may originate in narcissistic, exhibitionistic, aggressive, etc., drive tendencies. We also see that, for instance, reactive character formation, originating in defense against the drives, may gradually take over a host of other functions in the framework of the ego. That, under certain conditions, the ego's achievements can be reversible we see in neurosis, psychosis, in the dream, in analysis. Beyond this, we may say that ego functions, if activated, often tend to exert an appeal, sometimes more, sometimes less marked, on their unconscious genetic determinants; also that an attraction from the latter to the former takes place, and there is no doubt that some of this we find also in the normal waking life of what we would call healthy people. But there are relevant differences in the degree to which ego functions maintain their stability, their freedom from those potential regressions to their genetic antecedents. At any rate, in the healthy adult this partial reversibility is not incisive enough to create serious trouble. The degree of secondary autonomy, as I (1950a) have called this resistivity of ego functions against regression, is a problem equally relevant for our clinical, theoretical, and technical work. It is closely linked up with what we call ego strength and

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probably is the best way to assess it. The problem of secondary autonomy obviously also overlaps with the problem of mental health and has to be studied in normal development as well as from the angle of pathology.⁹

The relative independence of ego functions from id pressure can be expressed in terms of distance from ego-id conflicts, or distance from the regressive trends exerted by the id determinants. One aspect of the latter can, in terms of the energies involved, also be described as distance from sexualization or aggressivization. As to the developmental aspect of the ego functions' distance from conflict and distance from the drives, it appears relevant that newly acquired ego functions show a high degree of reversibility in the child and that special devices are used by him in his effort to counteract regression (A. Freud, 1951, E. Kris, 1951).

I may add that occasional regressions in the service of the ego (Kris) can be tolerated by the adult ego if its functions are unimpaired. We also know that the healthy ego, for certain purposes, has to be able to abandon itself to the id (as in sleep, as in intercourse). There are also other less well studied situations in which the ego itself induces a temporary discarding of some of its most highly differentiated functions (Hartmann, 1939b). To do this, not only without impairment of normal function but even to its benefit, is an achievement that has to be learned. The child up to a certain age is not capable of using this mechanism, or feels threatened by its attempted use. I think that this is probably one reason why the child fails vis à vis the demand of free association (Hartmann, 1939a).

Severe irregularities in the development of autonomy are relevant in pathology, and some of these problems apparently belong to what B. Rank (1949) has called the fragmented ego. We also have ample clinical evidence of the fact that even with the 'normal adult' not all functions of the ego achieve the same degree of stability.¹⁰

In concluding this paper, may I remind you that in the history of psychoanalysis modifications of concepts or new formulations of hypotheses often followed the opening up of new areas of research, as is the case in other branches of scientific work. At the present time, the integration of reconstructive data with data gathered through direct observation of early childhood represents one of the more pressing demands on our analytic thinking. My contribution to this symposium was presented with the aim in mind to facilitate the interrelation of these two sets of data. Some of the concepts and hypotheses I introduced, like the concept of

⁹ I decided maybe somewhat arbitrarily to omit from my discussion those aspects of "autonomy" that relate to superego function.

¹⁰ It seems that certain phenomena described by J. Lampl-de Groot (1947) are relevant in this context.

primary autonomy, or of secondary autonomy, will appear unfamiliar to many of you. But I found them to be useful tools, especially in dealing with those developmental problems we are mostly concerned with in this symposium. Although they were not used by Freud, I think they are consistently developed along the lines of his developmental theories.

When Anna Freud wrote her book *The Ego and the Mechanisms of Defense*, she refuted, in her introduction, the opinion, still held by many analysts at the time, that stigmatized the theoretical study of the ego as something essentially nonanalytic or even antianalytic. Since then, these studies have acquired full citizenship in analysis, on an equal level with the study of the id. There is no reason to assume that the desire to conquer "no-man's land" (to use an expression of E. Kris), to extend the reach of the analytic approach to psychological phenomena beyond its present limits, has come to an end. In Freud's ego psychology no less than in other parts of his work we find the kind of truths we would expect to be rather time resisting. But there is little doubt that he considered his outline of ego psychology, monumental as it appears to us, as a beginning rather than as a systematic presentation—in contrast to, let us say, his psychology of the dream, or of libidinal development, and that he considered this outline in need, but also capable, of reformulation and elaboration.¹¹

This symposium was of course meant to be a symposium on theory.¹² It deals with developmental and structural propositions. Obviously it would be impossible to present to you on this occasion also the great variety of individual clinical material and of data of direct child observation which underlie our hypotheses. Theory is in a way abbreviation but this is evidently not its only function. Our hypotheses help us to make of the raw material of our data a consistent and meaningful body of knowledge; it is only the formulation of definite propositions that makes our knowledge testable—that is to say accessible to verification or falsification—and which gives us the basis for valid predictions; it also helps us to ask questions which are meaningful and fruitful, and is a use

¹¹ I should like to emphasize here the very comprehensive character of the conceptual framework of Freud's ego psychology—though not all of its aspects and implications have so far been actually developed. It proves more useful than any other we know to serve our understanding also of those data of child development which have previously been found and described by other schools of psychologists. There is no reason for us not to avail ourselves of relevant observational data found by others (though their meaning will often be different if seen in our frame of reference) or not to study the methods they use. However I want to emphasize here that it appears for the most part unnecessary and often confusing to borrow, as has sometimes been done, the conceptual framework and the general theories of development from other schools of psychology or simply to superimpose other conceptual systems on that of Freud.

¹² This last paragraph is not part of the paper the author presented but part of the remarks he made in concluding the discussion.

ful tool in directing us toward areas of promising research. All this is well known and accepted elsewhere, and its importance in analysis is in principle not so much different from what it is in other branches of science. It would hardly be worth mentioning here, if it were not for the fact that the function of theory in analysis has not always been too well understood. One occasionally meets a tendency to limit psychoanalysis to a clinical specialty, and also a lack of awareness of how much, especially in analysis, the clinical approach owes to the highly complex structure of hypotheses developed by Freud and others. There is, with some, the habit of disparaging theory by equating it with 'speculation'. Or we hear complaints that the limitless and colorful diversity of individual clinical experiences is reduced in the process of hypothesis formation—which, again, disregards the fact that this reduction is one of the most general and most necessary characteristics of every scientific endeavor. There is no analyst who is not fully aware of the fundamental relevance of clinical observation in our field. It is not easy to see why the relevance of theoretical thinking is not likewise realized and why sometimes the natural emphasis on clinical data turns into a distrust of theory. The discussion of the role of hypotheses in psychoanalysis would no doubt deserve a special study. At this point I merely want to restate that analysis has been from its beginnings, and is most likely to be also in the future, more comprehensive in its outline, aims, and also means, than its clinical aspect. I mentioned to you before that one trend in Freud's work through all the years aimed at a general psychological theory, to exclude it from psychoanalysis would—*mutatis mutandis*—be somewhat like excluding physiological theory from physical medicine. Also, while we know how much Freud's work owes to his supreme capacity of observation and to his unflinching objectivity vis-à-vis new facts, we should not forget the extent to which the formation of crucial concepts and of 'good' hypotheses aided his discoveries as well as their meaningful interrelation. Actually, for a student of the history of analysis, Freud's work is a classical example of the point I am trying to make. It appears from such study, as a constant mutual promotion of observation and hypothesis formation. We come to understand how much poorer in dimensions and less fruitful also his clinical, also his technical work would have been had his power of theorizing failed to equal the power of his clinical insight. I do not think that the necessity, not only to enrich our clinical experience but also to develop the body of hypotheses we use in dealing with it, is less obvious today than it was in Freud's time.

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THE MUTUAL INFLUENCES IN THE DEVELOPMENT OF EGO AND ID EARLIEST STAGES

By W. HOFFER, M D (London)

I should like to narrow my task and concentrate on one aspect only the earliest differentiation of id and ego. In doing so I shall not be in a position to contribute anything relevant from the clinical point of view. Mental functioning in its onset is too controversial a subject to allow a satisfactory examination with a simultaneous view of the clinical problems related to it.

Some discrepancy between theory of clinic (psychopathology) and theory of early mental functioning will most likely be felt when research work on the psychogenesis and psychoanalytic treatment of psychosis like states are under discussion, and this has been recognized for some years past. In *The Problem of Anxiety* (1926) (*Inhibition, Symptom and Anxiety*) Freud already made this quite clear. He tentatively examined there the regressive processes which take place in early development resulting in obsessional mechanisms. He asked whether *regression* from the phallic to the anal sadistic level of instinct transformation should perhaps be accounted for by—as he called it—a *time factor* and not by a *constitutional factor*, which would promote *fixation*. 'It may be, these are Freud's words, 'that regression is rendered possible not because the genital organization of the libido is too weak but because the opposition of the ego begins too early, while the sadistic phase is at its height.' Clinical thought has since reorientated itself frequently on facts and theories referring to the development of the young ego but, no doubt, the balance is still in favor of pure reconstruction of early mental life based on clinical impressions. Direct investigations and observations made by psychoanalysts are still scanty and though in themselves most valuable are often unduly overrated or made up into generalizations. Today it can safely be assumed that a fast-growing new generation of psychoanalysts will finally tolerate and accept only those hypotheses related to the onset of mental life which have been arrived at by a close confrontation of factual material concerning early development with hypotheses primarily derived from clinical experience.

What now follows will be merely a summary of such theoretical and empirical statements as underlie our present day ideas on the early phases of id ego development and differentiation

THE DEVELOPMENTAL ASPECT OF THE ID

If the id can be conceived as rather immutable in its core, the nearer it comes to its cortical layer, the ego, the more does it appear plastic, colored by its objects beset with the consequences of functional changes, cathexes and anticathexes. And here also near its surface is the sphere where the developmental changes which we can safely attribute to the id manifest themselves. I mean of course the expression of the drives in terms of oral, anal, sadomasochistic, phallic and genital organization, and you will notice that whenever possible I shall speak of instinctual drives, implying the fusion of aggressive and erotic instincts.

The object of an instinct, according to Freud (1915, p. 65), is that *in* or *through* which it can achieve its aim. The object is the most variable thing about an instinct and is not originally connected with it, but becomes attached to it only in consequence of being peculiarly fitted to provide satisfaction. The object is not necessarily an extraneous one, it may be part of the subject's own body. It may be changed any number of times in the course of the vicissitudes the instinct undergoes during life, a highly important part is played by this capacity for displacement in the instinct.

There can never be enough stress laid on the distinction between the aim or objective of a drive, on the one hand, and its object 'peculiarly fitted to provide satisfaction,' on the other.

It is therefore in accordance with contemporary psychoanalytic usage to say that the developmental aspect of the id does not reach beyond that of the development from pregenitality to genitality.

We are used to viewing the mental processes of aging under the aspect of regression, of retrograde development. As far as this is conceived as instinct regression it is equally well delineated by the concepts of pregenitality and genitality.

THE BODY AS AN OBJECT OF THE ID DRIVES

The developmental aspect of the drives expressed in their progress through the different stages of pregenitality to genitality has steered us to a new mental structure, the *body ego*. According to Freud's description the body has to be conceived as the instincts' object and at the same time as a device for discharge closest to the source of the instinct. Instincts as such do not know or tolerate postponement of discharge. They

seek it in the object in or through which they can achieve their aim. They do not make their objects, they only make use of their availability. The "making of the objects" of the instincts in addition to what is there from the start, the body, is the result of the functioning of the ego.

INTERNAL MILIEU (INTERNAL ENVIRONMENT)

The ontogenesis of the ego is, as we know, one of the darkest chapters in psychoanalysis. In our ignorance of the origin of the instincts we have to resort to biology and biochemistry. We may say with Nunberg (1932) that the id has created its ego, but we still would like to know how it has done so. We can, however, see a little light if we conceive the body as the first object in which and through which an instinct not only seeks gratification, but which lends itself in an instinct regulating manner to this function.

Though the object is, as we have just said, interchangeable, it is there in the fabric of the body from the first moment when instincts came into operation. It provides psychologically Claude Bernard's *milieu interne*, the internal environment, which is created by the fact that instincts always flow out from a source to objects, in which they achieve their aim. The first psychological *milieu interne* of an ideal character is in our theory equated to *primary identification*, the functional aspect of *primary narcissism*. In her paper on 'Affects in Theory and Practice,' read fifteen years ago at the Marienbad Congress, Marjorie Brierley said on this: "At the beginning of mental life we are accustomed to posit a phase, prior to object differentiation and cathexis, that we label primary identification. This initial stage is by definition lacking in cognitive discrimination" (1951, p. 50). Brierley thinks that *primary identification* 'is presumed to be a state of feeling awareness' but that 'it can scarcely be devoid of sensory impressions. The very ambiguity of the English word 'feeling' indicates that this state is a fusion of sensory and object awareness'.

As examples to illustrate this Brierley still takes as Freud originally did, the infant's experiences with the mother's breast and its own mouth, whereas I should exemplify primary narcissism and identification by the infant's state of deep sleep. I assume that Bertram D. Lewin would do the same. What I mean is this: what happens in deep sleep we conjecture to be an almost complete withdrawal of cathexis. In it primary narcissism and identification, the lack of all qualities discriminating between self and not self, inside and outside, is temporarily achieved.

Sleep is interfered with at the beginning of life (where it is not yet conditioned by a preconscious sense of time) by instinctual needs which

call for objects in or through which gratification can be secured. Any instinctual demand that arises during deep sleep—including of course the demand for waking—will upset the state of primary narcissism and the "ideal internal milieu." Some of these urges find their objective forthwith with the aid of the body apparatus. The act of urination, for instance, or finger sucking, sucking of the lip or tongue, will relieve the need to discharge the urge, its *aim* being relief, some sensation of pleasure through or in the *object* in which the need was felt, parts of the infant's or fetus's body. In the case of micturition the sensory experience may extend over those parts of the body which become wet or cooler in consequence of evaporation, or it may cease altogether after micturition when urine is soaked up by a diaper, and so on. In the sucking experience the sensation will be reinforced by not-body objects, the milk, the breast, the bottle, the mother's grip, breath or heartbeat. When unpleasant sensations, some form of "pain" amounting to a "need," are felt by the infant, what apparatus is there to deal with them? I think at first none, except a biological (animal) "instinct" which works with motor discharges (Margaret Mahler's "affectomotor storm") which at first betray the absence of an organizing, synthesizing, integrating agency or ego. Such an "affectomotor storm" can be described at first in Freud's words (slightly modified) as the consequence of a departure from primary narcissism resulting in the body's vigorous attempt to recover it (1914, p. 57). *Organized* recoveries, from unpleasant stimuli, built up step by step, are first and foremost drawn from the infant's own body and are only possible with the help of *memory traces* (Glover, 1950). Thinking therefore in terms of simultaneous experiences of sensations aroused inside and outside, the feelings in the course of instinct gratification should lead to a reinforcement and temporary extension of the sensation of the self.

The more one thinks of young infants, their earthquake like reactions to pain which upsets the state of primary narcissism and defies primary identification, and of their initial indifference to stimulation from outside (before this becomes the source of pleasure) the more one is inclined to assume that "self" and "me" experiences are called upon to operate; they tend either to *preservation* or, if lost (in an attack of pain), to *restoration* of the inner equilibrium. The only mechanisms achieving this which I can conceive at this stage are those of negative and positive hallucination.

THE PROBLEM OF HALLUCINATION IN EARLY INFANCY

The concept of negative hallucination was mentioned on a few occasions by Freud, mainly descriptively, but in one instance he seemed to

accord it a high theoretical value¹ "Any attempt to explain hallucination," he said, "would have to be made from the starting point of a negative hallucination, rather than from a positive one" (1916, p. 148)

Positive hallucination has been readily accepted and used by psychoanalysts, including Freud himself, in explaining the infant's first attempts at need fulfillment but the negative has not. Negative hallucination we can conceive as a kind of sensory and affect deafness. It may at first be in operation against the disturbing influence of inner stimuli and it raises the physiological threshold of stimulation. When we fall asleep we sometimes have to make a definite effort to withdraw from the stimuli which still reach our various outer and inner sense organs, we have to use shutters to keep our awareness of any change, inside or outside, which would otherwise lead to stimulation and reaction. This we achieve with the help of repression. Negative hallucination means that a stimulus does not reach the sensory system. Perhaps it is not more than an effect of mobile energy which just balances the stimulus. Freud has commented on the work of mobile cathexis in a passage which, as far as I can see, has not yet been integrated into contemporary psychoanalytic thinking, but has recently been emphasized in the work of Hartmann. Kris and Loewenstein. In the third appendix to *The Problem of Anxiety (Inhibition, Symptom and Anxiety)* (1926) he says

When there is physical pain a high degree of what may be termed narcissistic cathexis of the painful place occurs. This cathexis continues to increase and tends as it were to empty the ego. It is well known that when internal organs are giving pain spatial and other images of the affected part of the body arise though that part is not represented in conscious ideation on other occasions. In contrast to that when the mind is diverted to some other interest by psychological means even the most intense physical pains fail to arise (I must not say remain unconscious in this case). This remarkable truth can be accounted for by the fact that there is a concentration of cathexis on the psychical representative of the part of the body which is giving pain.

It has obviously been easier for psychoanalysts to accept the concept of positive hallucination. In infant psychology it has been used to explain the affective experience of need fulfillment in a nonreal manner, as if the instinctual drive had reached its aim on the body organ in conjunction with an hallucinated, not an existent object, say the breast or the milk. Positive hallucinations dealing with the infant's hunger

¹ Freud did not refer to "primary repression" when mentioning "negative hallucination."

phenomena are always transient, other hallucinations may definitely pacify less vital instinctual needs more permanently

Negative and positive hallucinations work therefore in the service of instinct gratification and for the acquiescence of the self therein

Both forms of hallucination restore for a while, at least, the internal equilibrium, homeostasis In *positive hallucination* the absent part object of the instinct has definitely undergone a change—temporarily of course—as if it were there and gave satisfaction But this is hardly conceivable without postulating some kind of *memory traces* And this refers to the element of truth, in this case physical truth, reality, which according to Freud is generally operative in delusions Positive hallucinations can be conceived of only in an infant who had already experienced physically gratifications of the kind which are now hallucinated As they are related to memory traces, some kind of functioning ego has to be in operation as well

If we think of the reasons put forward by Freud when he said the dream is a psychosis, there is no objection to our saying that in certain infantile situations of need we conjecture that postponement of gratification is tolerated only by the aid of a psychotic mechanism

ORAL PRIMACY AND OBJECT

The progressive cathexis of the body is brought about in two ways, leading to a form of oral primacy first, by intensified oral stimulation, and second, by progressive differentiation of the oral intestinal apparatus followed by improving oral mastery of needs encroaching on the self (development of the body ego)

By intensified oral stimulation can be meant nothing else than the effect of motherly care It is not solely the consequence of the mother's acceptance of her child It is rooted in the child's need for more food, more attention in consequence of its fast growing, demanding body, and therefore in consequence of the lesser need for sleep Here factors of maturation enter the picture It leads to the subsequent enrichment of the inner milieu, the "*inner world of the infant*" by the memory traces and the actual pleasant experiences from better instinct channeling and control (avoidance of unpleasure and pain) The step to the psychological object, which now comes into existence irrespective of its physical presence or absence, has been taken

We have now to conceive of an ego's object, which is desired, which for instance draws cathexis away from the body, which can be looked at, and which progressively becomes separated from the exciting emotions (affects) inside, separated from the body-self experiences in the feeding

and nursing situation. As far as memory is already functioning it allows for very fine discrimination, but I do not think we can yet say at which level of early ego organization discrimination between *individuals*, of *fering* them as objects, can really be conceived to operate. Psychoanalysts seem in the past to have placed these processes too late, and the interest in the pioneer work of Ferenczi and his school, predominantly by Alice and Michael Balint, of Anna Freud, Spitz, Ribble, Greenacre and Bowlby, has already led to some modification of our timetable, while the work of Melanie Klein hypothesizes discriminating faculties in the infant from the onset of life.

SLEEP AND WAKEFULNESS

The infant's object relationship once in being, is annulled and re-created again psychologically and physically in rhythmic periods indicated by sleep and wakefulness.

Perhaps the mental experiences associated with awaking have, in our earliest, unconscious experiences as important a place as the feeding and nursing experiences. Psychologically the acts leading to awaking must be considered as bodyself experiences. Paul Federn (1932) has elaborated this aspect. Bodily sensations in the state of awaking are 'me experiences'. They ensue after the gratifying need to sleep has been fulfilled. Here no one can do more than describe impressions gained by chance observation. Nobody has examined this field with the eyes of a psychoanalyst so as to be able to offer us a more elaborate vista. We know, of course, that awaking is never merely the consequence of sleep need gratification. However, in very early life (fetal and neonatal) an active libidinal and aggressive longing for contact with a self, with objects and the outer world is difficult to conceive, it has to be *created*. This again is only conjecture, but I think it will be verifiable when the incubator, in which the prematurely born are nursed and fed, becomes the place for observation. Then we will be in a position to think how far the sleep-waking rhythm or, put in psychological terms, the state of primary narcissism and identification and the ego's 'vigorous attempts' to recover it, are part of an autonomous ego in the sense suggested by Hartmann. Autonomous factors can in future no longer be neglected.

The suggestion that we watch the infant's awaking from sleep or even the prematurely born in its incubator can safely be considered as what E. Kris (1951) termed 'action research'. Its results will not be confined to what passive observation (pure research of the behaviorists) reveals, but will depend on the observer's first intuitive understanding and reacting to the total situation observed. Examples of such understanding

based on empathy with the early mother child relationship have recently been put forward by D W Winnicott (1950)

SELF AND OBJECT

I believe, however, that as a consequence of our knowledge of the effects of deprivation in early infancy we have at present approached a stage in our applied child psychology where we interpret one-sidedly the infant's growing inner need to establish an object relationship. The emptying of the preconscious and unconscious of its cathexes—object, self, body—is of course not confined to the biologic rhythms of sleep, it operates for instance in fainting, in convulsions and above all, in the infant's states of *psychological helplessness* (M S Mahler's² "organismic distress"). Such states are more characteristic for the undifferentiated state of the id-ego relationship than for any later stage of ego development. They may occur without the noisy concomitants of the traumatic event of birth or of later traumas suffered by the active child, they may be "*silent traumas*"

These states of helplessness as such are not the subject under discussion today. What we cannot omit when discussing the earliest influences id and ego may exert on each other is the query: What are the psychological events which cause the helpless infant's body, self and the objects which have just entered into his life to be recathected? As in the state of gradual awaking, what still puzzles us are the methods which are employed to recover the state of *pretraumatic organization*, faint and fragile as it is. How does the constant flow of instincts lead to the recovery of the self, and do there remain residues, *loci minoris resistentiae*? Do they become re-enacted in the ego-dissociating events of later life, clinically called psychotic states and episodes?

We are not yet in a position to answer these questions, but we can relate the recovery from a state of helplessness to the infant's object relationship. I think we can assume that the infant's *sensitivity* to pain and unpleasure, its anxiety preparedness is gradually conditioned by the number, length and depth of the states of helplessness through which it passes (Greenacre, 1952). Its traumatized body as such does not easily provide the amount of stimulation, of body-ego experiences which the growing and recovering self longs for. The self is not regained, I assume, without the help of the object. The mechanism for achieving this is introjection as an instinct gratification which, according to Hartmann, is the forerunner of introjection as a defense mechanism. We cannot yet at this stage think of introjection as gratification and defense, as Joan

² See this Volume pp 286-305

Riviere (1936) has described it, or of projection which, according to Glover (1939), is by some observers regarded as characteristic of the mental apparatus from its earliest beginnings. With the aid of introjection the infant builds up again its narcissistic equilibrium, restores its "protective barrier." This is now secondary narcissism and thus paves the way for future genuine investments in the objects of the outer world. Self-control through object-control finally leads to transient object love.

Edward Glover (1947) whose theory of ego nuclei I have until now neglected postulates a traumatic loss of the object before the object-*imago* acquires the status of an ego nucleus.

CONCLUSION

I have made it my aim to trace the mutual influences in the development of the ego and the id back to the earliest stages of infantile life. I have decided to attempt this for two reasons: first, because a reorientation of the infant's psychology has been tried for quite a number of years by psychoanalysts and the only comprehensive reconstruction so far, the work of Melanie Klein and her co-workers, has in my opinion not taken fully into account the wealth of Freud's heritage on the one hand and of more recent child psychological research on the other. In this respect it is still orientated on the late Susan Isaacs' integrative endeavors. Second, Hartmann, Kris and Loewenstein's formulations of an undifferentiated phase allow now for a better explanation of the basic properties of the ego and the id. It deserves special emphasis that today Hartmann has put forward all evidence available at this juncture for assuming that the basic functions of the ego (control of perception, motility, memory, experience and learning) are not *created* by the needs, they are only *developed* under their influence; in fact they are inborn and their development, as he says, follows "certain laws, which are also part of our inheritance." From what he said I can deduce that psychic reality primarily results from the interaction of the drives with the inherited apparatus, secondarily from the interaction of both with the outer world. What I myself have to add is that the processes leading to the ego-id differentiation originate in the infant's body and that no environment exists until the self as a "me-experience" has come into existence. The body by these means, and here I am just repeating Freud, attains a special position among other objects in the world of perception. Instinct and ego maturation is also reflected in body-ego maturation. Though the environment deals successfully in many ways with the infant's needs, yet many situations of stress amounting to a loss of the feeling of the self must arise. I am inclined to believe that it is re-created again in a more arduous way

than we may imagine in the earliest acts of awaking. I am disposed further to believe that in the infant's frequently stated *inertia* there is an active element in operation which may be likened to Freud's concept of negative hallucination. The situation of inner stress may amount to traumas, and these may lead to the first anticipation of the affect of anxiety. The environment plays an active part in its mastery though it cannot entirely prevent it. From the occurrence of traumas and anxiety I deduce that an active drive toward the objects in the outer world emerges which is of course at the service of the oral partial instinct. With it the first object relationship ensues. A partial differentiation of the id and what there is of an ego has taken place.

I am reminded here of what Anna Freud (1951) in her Stockbridge paper called "telescoping." She said that our work with our patients deals with single events of the past which in fact turn out to be a long series of events, that the highly charged emotional experiences which they report and relive are in fact condensations (primary process) of numerous affects of childhood which, to an adult witness, would seem small, indeed almost insignificant. Our individual histories had to be drawn out if they were to approximate to what really happened. It would, however, take too long to listen to them. In trying to present a modern relief of the first months of life I have done nothing more than try to undo some of the telescoping we have done in our various theories of earliest infancy.

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THE MUTUAL INFLUENCES IN THE DEVELOPMENT OF EGO AND ID

Introduction to the Discussion

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In the introduction to his paper Heinz Hartmann stresses the point that the topic of the Mutual Influences in the Development of Ego and Id is so vast and all-important that the speakers to the symposium had better abandon the ambition to survey the problems in an objective manner and content themselves with offering their own personal avenues of approach to the subject. It seems to me that the speakers in the discussion have to claim the same privilege. The papers which make up this symposium are so comprehensive in their content, so closely argued and so well constructed that the discussion can do no more than concentrate on certain points, omit many others, i.e., select from the topics for further elaboration what is relevant for the personal outlook and interest of each contributor.

The relations between ego and id and the metapsychological exploration of their interdependence may well be used as a heading which covers more or less the whole psychoanalytic theory. According to the main clinical problems in any given period of analytic development, various theoretical aspects of these interrelations came into the foreground of discussions. Such aspects were: the contributions made from the side of ego and id (or rather by the systems Cs and Ucs, the qualitative concepts which preceded the structural ones) to the construction of a neurotic symptom; the part played by both in the infantile neurosis and in character formation; the intermingling of elements from both sides in the defense processes; the struggle between them for the control of function, illustrated by such contrasting processes as sexualization and sublimation; and their determining role in the perfection of an analytic technique which has to explore both sides of the personality, either simultaneously or in alternating phases. We can follow these attempts at theoretical understanding parallel with clinical work from the "Studies on Hysteria" and Freud's case histories through the intricacies of "active technique," "defense analysis," analysis of the "total personality," and of

"deep anxiety." It seems a natural development in our era, when in their clinical work so many analysts probe into the happenings of the first two years of life, that theoretical interest should be directed toward an understanding of the earliest beginnings of both sides of the human personality and their first influences on each other.

I. Development toward Object Relationship

The first point of interest which I select from many is the contribution made in the symposium to the much discussed stages of development in infancy toward so-called full object relationship. All contributors, the present writer included, agree that there are such stages, though every author approaches their explanation from a different angle.

W. Hoffer offers help in this respect by his differentiation between a stage when the object, though it belongs to the environment, is treated as part of the *milieu interne*, serves the satisfaction of the infant's inner needs in the same manner in which these needs are served by the infant's own body, and has no existence for the child apart from these needs. Hoffer's line of demarcation between this primitive form of object relationship and the relationship to a later "psychological" object is built on the distinction that the former is included in the narcissistic processes of libido cathexis whereas an object reaches the status of "psychological object" when it entices cathexis away from the body, thereby changing narcissistic libido into true object libido.

In H. Hartmann's exposition the same two stages of object relationship appear as the relationship to a "need-satisfying" object and the status of "object constancy" respectively. According to him, it is characteristic for the need-satisfying object that it is dropped, ceases to exist, loses its role, when no instinctive need is felt; it becomes reinstated with the reawakening of needs. Hartmann assumes, very similarly to Hoffer, that the transition from the primitive form of intermittent object relationship to object constancy is accomplished by changes in the quality of object cathexis. But where Hoffer describes a transformation of narcissistic into object libido, Hartmann makes the more far-reaching assumption of a change from instinctive to neutralized cathexis. It is this transformation of instinctive into neutralized energy to which he attributes the child's newly developing ability to maintain constant relations with objects, regardless of the state of need. This is in accordance with Hartmann's view that neutralization of energy is the basis of most of the individual's advances from the state of a primitive being, dominated by his instinctive urges, to an adult human personality under reasonable ego control.

The views of both authors coincide, at least in approximation, with

the differentiation made by Melanie Klein between the stages of part object and whole-object relationships. Though at first glance Melanie Klein's differentiation seems orientated by the type of object, not by the nature of the cathective process, some change in the quality of the latter is implied probably in her assumption.

The present writer's views on the same subject lean toward a quantitative rather than qualitative explanation. When studying a group of infants in situations of extreme need after separation from their mothers,¹ I developed the idea that the step from the first to the second stage of object relationship—from the *milieu interne* to the psychological object (Hoffer) from the need satisfying object to object constancy (Hartmann) from part objects to whole objects (Melanie Klein)—is determined by a decrease in the urgency of the drives themselves. We may assume that the impact of the drives, or of the needs which represent them, is most imperative at the beginning of life, we know for certain that this is true, relatively at least, in relation to the ego organization which is either nonexistent or weakest at this time. While the infant is under the full impact of his needs—in terms of mental functioning, completely dominated by the pleasure principle—he demands from the object one thing only, that is immediate satisfaction. An object which fails to fulfill this purpose at a given moment cannot be maintained as such and is exchanged for a more satisfying one. The needs have to lessen in strength or have to be brought under ego control, before nonsatisfying (for instance, absent) objects can retain their cathexis. This statement is borne out by the behavior of young children under the influence of separation from their mothers. In the earliest months of life it seems possible to exchange the object provided the form of need satisfaction given to the infant remains unaltered. Later (appr. after five months) the personal attachment to the object increases in importance, it becomes possible then to vary the satisfactions, provided the object remains the same. At that stage (appr. five to twenty-four months)² separation from the object causes extreme distress, but the infant is so exclusively dominated by his needs that he cannot maintain his attachment to a non-satisfying object for more than a given period (varying from several hours to several days). After this interval, which is most upsetting for the

¹ See Dorothy Burlingham and Anna Freud *Young Children in War Time*, George Allen & Unwin Ltd., for the New Era, London, 1942. As Ernst Kris (Notes on the Development and on Some Current Problems of Psychoanalytic Child Psychology, *This Annual* 4, 1950, p. 33) has pointed out the distinction discussed in this monograph and above coincides with and is influenced by Freud's distinction between the danger of losing the love object and that of losing the object's love.

² The differentiation of reactions which occur during this extended period are neglected here.

child, need satisfaction is accepted from and attachment (cathexis) is transferred to a substitute. As the ego matures and the pleasure principle yields to the reality principle, children gradually develop the ability to retain libidinal cathexis to absent love objects during separations of increasing lengths.

Under the influence of certain neurotic and psychopathic disturbances in adult life, this development may become reversed. The individual regresses then once more to the earlier level of merely need satisfying and therefore transient and intermittent object relationships.

II Partial Ego Concepts

In discussing in general the scope of psychoanalytic ego psychology, Hartmann speaks of the different facets of the ego, as they have been worked out by different analysts. He realizes that 'to emphasize one partial concept of the ego only, at the expense of other aspects may be a question of expediency vis à vis specific problems but he cautions at the same time against the one-sided view of the ego which results when studies are pursued in one direction only. According to Hartmann, we can arrive at an all round picture of the ego only if we add up the contradictory impressions gained from investigating ego functioning, ego qualities and ego attitudes under the most varied conditions, 'from the angle of the resistances, in the study of psychosis and in the direct observation of children'. 'The reality ego, the defensive ego, the organizing the rational ego, the social ego the ego that leads a shadowy existence between the great powers of the id and the superego, the ego evolving under the pressure of anxiety situations are not 'the ego' in the sense of analytic psychology. These are partial concepts to be distinguished from Freud's general ego concept."

I should like to illustrate this warning by reference to the "defensive" ego. I know from personal experience that, while studying the defense mechanisms of the ego, the investigator runs the risk of stressing one-sidedly the hostility between ego and id, at the expense of the co-operation which exists between them. While observing the utter helplessness of an ego which is overrun by id desires, swamped by an anxiety attack, or which defends itself with infinite resourcefulness against id urges (as for instance in an obsessional neurosis), one is apt to forget the original basic unity between the two powers i.e., that the ego was evolved out of the id as a helpmate, to locate the best possibilities for need satisfaction and object attachment and to safeguard wish fulfillment amid the hazards and dangers of the environment. The ego's role as an ally of the id precedes that of an agent designed to slow up and obstruct satisfaction. Moreover, the ego retains the former beneficial role toward the id in all

those instances where the id drives pursue permitted, i.e., ego syntonic, aims³

III The Concepts of an Undifferentiated Id Ego

When trying to keep in mind the basic unity between id and ego, the analyst meets once more the same difficulties which existed for long periods concerning the separation between ego and superego concepts. Used to the picture of neurotic conflicts where ego and superego are at loggerheads with each other, analytic writers committed the mistake of treating the two agencies in the mind as two different personalities altogether, instead of seeing them as one (the ego organization), whenever their aims coincide, the division between them merely becoming visible to the eye of the observer in those instances where their aims differ from each other in a decisive manner.

When discussing the initial unity between id and ego Hartmann reminds us of the concept of an 'undifferentiated ego-id'⁴ from which the id-ego differentiation arises on the basis of inner and outer perception, motility, preconscious memory traces, experience and learning. This concept can be helpful to our thinking in various ways. If the ego arises out of the same undifferentiated matter as the id, it becomes comprehensible that it partakes in the hereditary factors which we recognize as operative in the development of the drives. Hartmann suggests that we can trace in the development of the ego laws of maturation which are as much a part of our biological inheritance as the laws of maturation which govern the well known sequence of libidinal development (oral, anal, phallic), or the less well-studied phases of aggressive development. An assumption of this kind can only be based on the conception of a nondifferentiated id-ego phase. When it is followed up, in the direction suggested in Hartmann's paper, it goes a long way toward solving a major misconception in the field of ego psychology, namely, that it is one of the basic differences between id and ego that the id contents the drives develop according to innate laws, while the ego develops wholly under the impact of environmental, reality, factors i.e., as the result of 'learning'. Though environmental influence, against which the id is immune, plays a major part for the ego, the assumption of a primary nondifferentiated ego-id brings the two main agencies in the personality structure nearer to each other again and leaves room in the ego for innate, hereditary factors.

³ I owe a great deal to Hartmann for pointing out this dichotomy to me at a time when I was engaged in writing my book on *The Ego and the Mechanisms of Defence*.

⁴ Freud, *S. Outline of Psycho-Analysis*.

IV. Primary Ego Autonomy

Hartmann speaks of those elements in the ego which originate in the hereditary core and which enter ego development "as an independent variable" as the "autonomous factors in ego development (primary autonomy)." He differentiates in this respect between the functions, such as adaptation, synthesis, or even self-preservation (to which he ascribes biological origin), and the apparatus serving perception, memory, motility which are indispensable for the exercising of these functions. Though, especially in the infant, the action of these apparatus seems to be prompted by instinctual needs, Hartmann stresses his conviction that they are not created by these needs, that they too are, at least partly, inborn and that their maturation is subject to inherited laws. It is important, according to him, that the working of these apparatus is brought gradually under the control of the ego; on the other hand he shows it to be of equal importance to recognize how far ego development itself is tied to the maturational stages in the motor and sensory apparatus and takes its cue from them. He describes the apparatus as being activated by instinctual energy (libidinal and aggressive) which becomes increasingly neutralized in those functions which serve exclusive reality aims, regardless of instinctual need.

With this threefold concept of an independent apparatus, activated by energy borrowed from the drives and gradually brought under the control of the ego, Hartmann offers us a first opportunity to shed light on some areas of child development which are governed at present by confusing and contradictory hypotheses. There seems little doubt that academic psychologists err on the side of conceiving of the various apparatus serving motor and sensory development as too independent of the drives, whereas psychoanalysts err in the opposite direction in attributing every failure in the proper functioning of the apparatus to a disorder on the side of the instinctual drives and their distribution (object relationship). On the basis of Hartmann's theoretical setup, we can arrive now at the following clinical considerations:

When a child's ego is retarded in its development, this may happen for three different reasons: (i) because of an inborn, or acquired, defect in the motor or sensory apparatus themselves; (ii) because of some failure in the normal development of the drives, as a result of which the apparatus receive insufficient activation or overstimulation; (iii) because of failure to bring the various apparatus under ego control, which points to a serious hold-up in the child's reality sense. Even if, in the investigation of an actual clinical case, we should find that these three factors interact with each other, we should profit from separating them off from each other and assessing their relative pathogenic strength. There are

many among us who find it difficult to believe that failure in the early object relationships (i.e., 'rejection by the mother') should be powerful enough as an agent to suppress the innate possibilities of orientation in reality, speech and motor development in a child whose sensory and motor apparatus is intact. On the other hand we all know the powerful instinctual and emotional influences which produce what is commonly called pseudodebility. Hartmann's threefold picture of ego development leaves room for the latter while providing at the same time for the possibility of 'real' mental deficiency, a term which might be reserved for disturbances caused by a defect in the apparatus itself.

There are two profitable methods of teaching backward or retarded children which seem to bear out Hartmann's theories. The first one consists of using for teaching purposes only such images and concepts which have a direct bearing on the child's emotions (big animals, scenes of violence, stories where eatables or dirt, mishaps to others etc., play a part). Instinctive energy (libidinal or aggressive) will overflow from the drives to these images and activate the intellectual apparatus (defective or normal, as it may happen to be) to a larger degree. We can call this device an enforced 'sublimation' or, viewed from the other side, a 'sexualization' (cathexis with aggressive energy).

The second method consists of improving the object relationships of mentally defective children. This has been done experimentally in Iowa, U.S.A.² and confirmed by intelligence testing. The children in the experiment, with low I.Q.'s were removed from the residential institution in which they were living, and brought into favorable emotional conditions in family surroundings, with the result that their I.Q. on retesting showed considerable improvement. In these cases we might surmise that the blossoming out of emotional attachments and identifications had favorable results for the development of the child's reality ego and brought apparatus under ego control which had functioned formerly under the influence of needs and drives only.

V. Secondary Ego Autonomy

My final point is concerned with what Hartmann calls the 'resistivity,' or 'irreversibility,' or the secondary autonomy of the ego. Under these headings he discusses the problem how far ego interests, qualities and attitudes become independent of the instinctual tendencies or the defense mechanisms against instinctual tendencies from which they have arisen. Hartmann shows that we know from the observation of dreams

² See Harold M. Skeels, *Mental Development of Children in Foster Homes*. *J. Consult. Psychol.*, 11, 1933.

neuroses and psychoses that ego achievements can be reversed and regress to their genetic antecedents. On the other hand, we know from experience that ego interests which originate in narcissistic, exhibitionistic, aggressive, etc., tendencies may persist a lifetime as valuable "sublimations," regardless of the fate of the original part instincts which gave rise to them. In Hartmann's words "reactive character formation, originating in defense against the drives, may gradually take over a host of other functions in the ego" and continue to exist long after its function as defense mechanism has ceased to be important. Hartmann points out further that even where a repressed drive has been emptied of cathexis, as it occurs in the course of instinctual development, this may serve merely to strengthen the stability of the ego formation which has been built on it. Hartmann calls this "secondary autonomy" of the ego its real 'strength,' regards it as highly important for the stability of our personalities and, as a concept, as relevant for our clinical, theoretical and technical work.

Analytic observers of child development will agree with Hartmann that the increasing ability of the ego to stand firm in the face of upheaval outside its own realm is one of the significant steps on the way to maturity. We are familiar with the idea that the integrity of the child's ego is threatened from more than one side. It has been described often how insecure the ego achievements are during the time of development when the child's identifications with the parents are incomplete still and run a parallel course with the object relations to the parents, i.e., before the superego has detached itself finally from the object figures in the environment. Reaction formations which enrich the ego, such as cleanliness, disgust, pity, shame, modesty, or social adaptations such as honesty, fairness, consideration for others can go by the board in situations when the child's love for the parent changes to hate or hostility or when the bond with the love object is broken. Even as late as adolescence, revolt against the parents is followed by the rejection of identification with them and can lead to reversals of superego and ego attitudes, though apparently these attitudes had been fully integrated in the ego structure of the latency child.

From the side of the id, it is above all regression of instinct development which has a harmful effect on the immature ego. When, under the influence of a traumatic experience such as separation anxiety, or any of the anxieties and conflicts of early childhood, an infant regresses from a later to an earlier level of instinct development, this backward move is accompanied almost invariably by some undoing of ego achievements. Here, as in the realm of the superego reversals mentioned above, it is the most recently acquired functions of the ego which are most threat

ened. When, for instance, infants regress from the anal to the oral level while they are beginning to speak, they lose their speech almost regularly. The same is true for the beginning of walking which may regress to crawling under the influence of instinctual regression, the same is true also for the loss of bowel and bladder control. In the case of walking, this function is already independent of instinctual upheavals a few weeks after its beginning.⁶ The ability to speak will remain immune—except in cases of grave psychotic disorders—after approximately six to twelve months from its establishment. Bowel and bladder control on the other hand may remain susceptible to id disturbance, i.e., reversible, during the whole period of early childhood.

That the immature ego cannot maintain its achievements under all circumstances seems to me to have a direct bearing on the difference between adult and infantile neuroses. In the adult neurotic the pathogenic conflict arises between an instinctual drive which has regressed to an early primitive level and an ego which has remained intact. The outcome is rigid symptom formation as a compromise between two internal forces which are incompatible with each other. This takes a different course in the immature personality in those cases where the ego does not stand firm under the pressure of instinctual regression, but regresses simultaneously. The gap between the two internal agencies is lessened in the event of such 'total regression,' i.e., the regressed ego becomes compliant toward the regressed id demands. This avoids the intensity of internal conflict for the child, but produces instead the multitude of abnormalities, hold ups in development, infantilisms, failures in adaptation which we group together vaguely as emotional disturbances of childhood development.

It is in line with this statement that the few circumscribed and rigid neuroses which we find in early life occur in children whose ego development is unusually good and even premature (as it is in obsessional children), i.e., where the secondary autonomy of the ego has been established at an early date.

The children of our generation are brought up more leniently than before and, consequently, seem to take longer before they establish a firm ego structure. This may account for the fact that the less well-defined and fluctuating developmental disorders are on the increase at the expense of the real infantile neurosis which was more frequently recorded and treated by the analytic workers of the past.

⁶ Excepting certain typical occurrences which have been insufficiently studied so far.

THE MUTUAL INFLUENCES IN THE DEVELOPMENT OF EGO AND ID

Discussants

MELANIE KLEIN (London)

In 'Analysis Terminable and Interminable,'¹ which contains Freud's latest conclusions about the ego, he assumed ". . . the existence and importance of primary congenital variations in the ego" I have for many years held the view, and expressed it in my book, *The Psycho-Analysis of Children*,² that the ego functions from the beginning and that among its first activities are the defense against anxiety and the use of processes of introjection and projection. In that book I also suggested that the ego's initial capacity to tolerate anxiety depends on its innate strength, that is to say, on constitutional factors. I have also repeatedly expressed the view that the ego establishes object relations from the first contacts with the external world. More recently I defined the drive toward integration as another of the ego's primal functions.³

I shall now consider the part which the instincts—and particularly the struggle between life and death instincts—play in these functions of the ego. It is inherent in Freud's conception of the life and death instincts that the id as the reservoir of the instincts operates *ab initio*. With this conception I fully agree. I differ, however, from Freud in that I put forward the hypothesis that the primary cause of anxiety is the fear of annihilation, of death, arising from the working of the death instinct within. The struggle between life and death instincts emanates from the id and involves the ego. The primordial fear of being annihilated forces the ego into action and engenders the first defenses. The ultimate source of these ego activities lies in the operation of the life instinct. The ego's urge toward integration and organization clearly reveals its derivation from the life instinct. As Freud put it, ". . . the main purpose of Eros—that of uniting and binding. . ."⁴ Opposed to the drive toward integration and yet alternating with it, there are splitting processes which, together with introjection and projection, represent some of the most fundamental early mechanisms. All these, under the impetus of the life instinct, are from the beginning pressed into the service of defense.

¹ *Collected Papers*, London: Hogarth Press, 1937.

² London: Hogarth Press, 1932.

³ Notes on Some Schizoid Mechanisms *Int J Psy*, XXVII, 1946.

⁴ (1923) *The Ego and The Id* London: Hogarth Press, 1927, p. 64.

Another major contribution from instinctual drives to the primal functions of the ego needs consideration here. It is in keeping with my conception of early infancy that fantasy activity, being rooted in the instincts, is—to use an expression of Susan Isaacs—their mental corollary. I believe that fantasies operate from the outset, as do the instincts, and are the mental expression of the activity of both the life and death instincts. Fantasy activity underlies the mechanisms of introjection and projection, which enable the ego to perform one of the basic functions mentioned above, namely, to establish object relations. By projection, by turning outward libido and aggression and imbuing the object with them, the infant's first object relation comes about. This is the process which, in my opinion, underlies the cathexis of objects. Owing to the process of introjection this first object is simultaneously taken into the self. From the outset the relations to external and internal objects interact. The first of these "internalized objects," as I termed them, is a part-object, the mother's breast; in my experience this applies even when the infant is bottle-fed, but it would take me too far if I were to discuss here the processes by which this symbolic equation comes about. The breast, to which are soon added other features of the mother, as an internalized object vitally influences ego development. As the relation to the whole object develops, the mother and the father, and other members of the family, are introjected as persons in good or bad aspects, according to the infant's experiences as well as according to his alternating feelings and fantasies. A world of good and bad objects is thus built up within, and here is the source of internal persecution as well as of internal riches and stability. During the first three or four months persecutory anxiety is prevalent and exerts a pressure on the ego which severely tests its capacity to tolerate anxiety. This persecutory anxiety at times weakens the ego, at other times it acts as an impetus toward the growth of integration and intellect. In the second quarter of the first year the infant's need to preserve the loved internal object, which is felt to be endangered by his aggressive impulses, and the resulting depressive anxiety and guilt again have a twofold effect on the ego: They may threaten to overcome it as well as spur it on toward reparation and sublimations. In these various ways at which I can only hint here the ego is both assailed and enriched by its relation to internal objects.⁵

The specific system of fantasies centering on the infant's internal world is of supreme importance for the development of the ego. The internalized objects are felt by the young infant to have a life of their own, harmonizing or conflicting with each other and with the ego, according to the infant's emotions and experiences. When the infant feels he contains good objects, he experiences trust, confidence and security. When he feels he contains bad objects he experiences persecution and suspicion. The infant's good and bad relation to internal objects develops concurrently with that to external objects and perpetually influences its course. On the other hand, the relation to internal objects is from the outset influenced by the frustrations and gratifications which

⁵ The most up-to-date presentation of these early processes is contained in the forthcoming book, *Developments in Psycho-Analysis*, London: Hogarth Press, 1952.

form part of the infant's everyday life. There is thus a constant interaction between the internal object world which reflects in a fantastic way the impressions gained from without and the external world which is decisively influenced by projection.

As I have often described, the internalized objects also form the core of the superego⁶ which develops throughout the first years of childhood, reaching a climax at the stage when—according to classical theory—the superego as the heir of the oedipus complex comes into being.

Since the development of ego and superego are bound up with processes of introjection and projection, they are inextricably linked from the outset and since their development is vitally influenced by instinctual drives, all three regions of the mind are from the beginning of life in the closest interaction. I realize that in speaking here about the three regions of the mind I am not keeping within the topic suggested for discussion, but my conception of earliest infancy makes it impossible for me to consider exclusively the mutual influences of ego and id.

Because the perpetual interaction between the life and death instincts and the conflict arising from their antithesis (fusion and defusion) govern mental life, there is in the unconscious an ever-changing flow of interacting events of fluctuating emotions and anxieties. I have attempted to give an indication of the multitude of processes focusing on the relation to internal and external objects which from the earliest stage onward exist in the unconscious and I shall now draw some conclusions.

(1) The hypothesis which I have broadly outlined here represents a much wider view of early unconscious processes than was implied in Freud's concept of the structure of the mind.

(2) If we assume that the superego develops out of these early unconscious processes which also mold the ego, determine its functions and shape its relation to the external world, the foundations of ego development as well as of superego formation need to be re-examined.

(3) My hypothesis would thus lead to a reassessment of the nature and scope of the superego and of the ego as well as of the interrelation between the parts of the mind which make up the self.

I shall end by restating a well-known fact—one of which, however, we become more and more convinced the deeper we penetrate into the mind. It is the recognition that the unconscious is at the root of all mental processes, determines the whole of mental life and therefore that only by exploring the unconscious in depth and width are we able to analyze the total personality.

⁶ The question arises: How far and under what conditions does the internalized object form part of the ego, how far of the superego? This question I think raises problems which are still obscure and awaiting further elucidation. In a forthcoming publication Paula Heimann has put forward some suggestions in this direction (*Developments in Psychoanalysis* to be published by the Hogarth Press 1952).

S NACHT, M.D. (Paris)¹

The problem of the ego figures importantly in the psychoanalytic literature of the last thirty years. A good many of these studies, however, have not only failed to give us a clearer understanding of this highly complex issue, but rather have served even further to confuse our ideas about it.

This impression of confusion becomes especially marked when we compare these recent contributions with the last writings of Freud (*An Outline of Psychoanalysis*, 1938), where we find the most valid hypotheses on this subject lucidly stated in a few lines.

Ever since I presented a paper on ego functions at the First Franco-British Reunion of Psychoanalysts in Paris in June, 1939,² I have been reproached with oversimplification by some of those who in the meantime have pressed forward very far with their investigations of this problem. If I may judge from the publications of the last few years, the opposite tendency undoubtedly has prevailed since. These works precisely illustrate an aspect of the development of our science whose alarming possible consequences I wish to emphasize.

As an example, let us take the highly thoughtful and persevering studies of Hartmann, which are almost entirely devoted to the problem of the ego and in which the author develops some very personal views on the question. If I understand his conception correctly, the ego would not consist exclusively in a differentiation of the id under the influence of the reality of the environment, partly, it would have an origin of its own—autonomous and independent of the id—and be endowed with equally autonomous functions and energetic sources.

After referring to the theory advanced by Freud, according to which "id and ego are originally one," and after he has himself stressed the fact that "both the ego and the id have developed, as products of differentiation, out of the matrix of animal instinct," Hartmann takes the unexpected line of declaring that a part of the ego is, nevertheless of autonomous origin. At this point it becomes difficult for us to follow him, at least, as long as he fails to supply any facts to support this hypothesis. For this "matrix of animal instinct," which constitutes the common origin of both the id and the ego, cannot be anything else but the whole of the instinctual elements determining the child's life from its very first months.

It is therefore not clear, for example, how we are to understand the following passage from Hartman's "Comments on the Psychoanalytic Theory of the Ego"³ in which he states "that the ego may be more—and very likely is more—than a developmental by-product of the influence of reality on instinctual drives that it has a partly independent origin—apart from these formative in-

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³ *This Annual*, V, 1950.

fluences which, of course, no analyst would want to underestimate, and that we may speak of an autonomous factor in ego development in the same way as we consider the instinctual drives autonomous agents of development. Of course, this is not to say that the ego as a definite psychic system is inborn, it rather stresses the point that the development of this system is traceable not only to the impact of reality and of the instinctual drives, but also to a set of factors that cannot be identified with either one of them."

Finally, in the paper presented by him at this Congress, Hartmann suggests the idea that this "autonomous origin" might consist in hereditary factors, thereby contradicting a certain part of the text quoted above, to which he seems to admit that the ego "as a definite psychic system is not inborn."

If Hartmann believes that the instinctual elements cannot by themselves account for the formation of the ego, and if, in his opinion, other factors are involved we might ask that he specify what they are. For it is not enough to mention the influence of learning, for instance, or of language, or of maturation, to prove anything whatever concerning an autonomous origin of the ego. Is not learning which comes about due to the pressure of the outside world, already in itself the differentiation that a part of the id undergoes in the course of becoming the ego? As to maturation, Hartmann will not contradict me if I recall that from the psycho-affective point of view it indicates a stage in the development of the ego—that is to say, not a point of departure but a result.

And even the physiological-somatic aspect of maturation, to which Hartmann⁴ at times seems to refer, represents merely a sum of anatomical and functional conditions that occur as successive steps in the course of development and unquestionably subsequent to the cleavage of ego and id.

I am convinced that the only way in which we can avoid these confusions—these persistent and to my mind sterile discussions—is to remain strictly on the ground of biology and dynamics. In other words, the phenomena with which we are concerned must be considered by us on the level of needs and of functions resulting from the latter.

It is essentially thanks to the study of psychic life from this dynamic and biological angle that psychoanalysis has proved so fruitful in discoveries permitting us a better understanding of human behavior.

The attempt to raise psychoanalysis toward the heights of general psychology—as Hartmann, Odier⁵ and de Saussure⁶, among others—would like to do seems to me a sterilizing and regressive step. To say the least if it is aimed at a change of our methodology. For is not psychoanalysis, in fact, the very basis of general psychology and must it not be credited with the latter's most profound and most valid insights?

But let us return to the questions that concern us here and, if we wish to avoid confusion from the very beginning, let us beware above all of a grievously

⁴ Technical Implications of Ego Psychology *Psy Quart*, XX, 1951

⁵ *L'Angoisse et la pensée magique* Neuchâtel Delachaux et Niestlé 1947

⁶ *Rapport à la première Conférence mondiale de Psychiatrie, 1950* Paris Hermann et Cie

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widespread misconception for which Freud himself is partly responsible. While indeed he takes pains to make it clear that to him the ego and the id merely represent didactic concepts or working tools, he also employs such terms as psychic apparatus, psychic province, psychic entity, cortical zone, etc

In the minds of many people images of this kind finally have come to be confused with physical realities of which no proof has been offered. Today we find, not without surprise, that certain analysts with a stroke of the pen are turning the ego, the id and the superego into "organs." This almost amounts to making of them 'persons' within the person himself—which logically leads to their being invested with, among other attributes, autonomous origins and functions.

In reality, none of us has succeeded in detecting any psychic instances or entities. Our observations reveal the existence of psychic processes, which is a very different matter. And this point needs to be stressed, I believe, in order to find our way out of the maze of subtleties in which we are becoming lost. There is no such thing as a psychic entity, there only exist psychic processes. What we call the ego is one of these processes. It is a process that is set in motion and becomes operative when the organism finds itself exposed to certain stimuli which we are able to observe and which have been defined by Freud (in the work cited above) the vital needs on the one hand, which with the aim of gratification induce energetic movements that we describe as instinctual drives and, on the other hand, an environment containing the object designed to supply this gratification. These two sources of stimulation determine the processes which constitute the functions of the ego. These classical conceptions are known to us all. I mention them here because they are in danger of being assigned to a secondary place, whereas actually they are fundamental.

The stimuli essentially remain the same, although it is true that in the course of the child's development they undergo continual shadings due to physical maturation and changes in the environment, thereby entailing modifications in the functions of the ego.

As an example we may mention the body image whose importance in the formation of the ego functions has frequently been emphasized. It is understood, of course, that I am referring here to the ego in its specific psychoanalytic meaning and not in the sense of awareness of the self. The body image probably begins to take shape in its unity from the sixth month on (Lacan mirror stage). By unity, I mean that it is then perceived as being at the same time one (synthesis) and separate from the environment.

Now, this corresponds exactly to the age at which the maturation of the pyramidal system as well as the myelination of the fibers of co-ordination begin to take place, i.e., to the start of voluntary motility. Thus it seems that the originally diffuse, incoherent, internal bodily perceptions must first become capable of being consolidated and projected outward in action conducive to the gratification of instinctual needs, before such feeling of the unity of the ego can be established. It goes without saying that the reaction of the external environment develops in correlation to the changes taking place in the child.

The interrelationship we can see here between the establishment of func-

tions and the maturation of the physiological systems is a constant feature in itself. It remains to be determined, however, up to which point the physiological maturation proceeds independently of the adaptive processes that are attached, precisely, to the functions of the ego.

I submit to you for consideration the following fact which appears to me worthy of attention. Certain automatisms observed in the newborn—some neonatal elements of motor activity, for instance—disappear immediately after birth, to reappear later when voluntary motility sets in.⁷ One might speculate whether this peculiar, transitory regression, which can only be observed, I believe, in the human organism, is not connected with the disturbance based upon the increasing difficulty of adapting the internal environment—particularly the drives—to the external environment until such time as this task of adjustment is taken over by the ego functions.

However this may be, whether we speak of voluntary motility, language, or any other phases of learning, we must not forget that the energetic source in which they have their origin remains in the service of the needs of the organism. It would be a grave error to attribute to them any energetic or functional autonomy in relation to the drives. I do not know of any fact that would support this hypothesis, nor have I found anything in the literature to prove it. Loewenstein⁸ it is true, reports two cases which in his view serve to illustrate this theory, but there is nothing contained in these observations which, in my opinion, would justify the conclusions he draws from them in favor of ego autonomy.

On the contrary, everything in our daily observations shows that the energetic sources of the ego are consistently derived from the aggressive and sexual drives. In various studies on masochism,⁹ on the ego¹⁰ and on aggression,¹¹ I have called attention to the preeminently conflictual role of aggression.

I have endeavored to demonstrate that the nonintegrated aggressive drive constitutes the disturbing element *par excellence* in relation to the ego functions. I am speaking intentionally of *integration* of this drive and not of neutralization, since the neutralization of aggression—even if it were possible—would, in fact, deprive the human organism of one of its basic energetic sources.

All this leads us back, therefore, to the classical conceptions of the origin and functions of the ego. Their validity has been proven through clinical testing; they have acquired the seal of effective demonstration.

Praise is due, to be sure, to those who strive to extend ever further the limits of our knowledge and who devote such great intelligence to very valuable studies. But I fear that these efforts may prove vain because they have taken the path of a 'psychologism' which is leading them far away from the living sources of psychoanalysis, from everything that is most fundamental in it and most fruitful. Obviously we cannot content ourselves with stagnation and with

⁷ Ajourniagera J. *Structure Neurologique et Fonction*, 1951.

⁸ Conflict and Autonomous Ego Development During the Phallic Phase. *This Annual*, V, 1950.

⁹ *Revue Française de Psychanalyse*, 1938.

¹⁰ *Op. Cit.*, note 2.

¹¹ Clinical Manifestations of Aggression and Their Role in Psychoanalytic Treatment. *Yearbook of Psychoanalysis*, VI. New York: International Universities Press, 1950.

eternal resifiting of the same conclusions. But perhaps we should now turn to modern physiology for aid and assistance if we wish to advance further, for the work of reconstructing through the analysis of the adult what takes place in the child has, in my opinion, yielded everything that could be expected of it.

Hartmann and Hoffer frequently mention in their papers the importance of the physiological approach, and in this field I go along with them most willingly. Indeed, the modern physiological studies demonstrate ever more forcefully the interdependence between emotional and psychic life on the one hand, and the neurovegetative and endocrine functions on the other. Selye's latest works, in particular, contain findings that are of considerable import. It is obvious that we should be able to obtain extremely interesting results if we were to co-ordinate direct psychoanalytic observations of children, such as those initiated by Anna Freud and by Spitz, with some parallel study based on the latest physiological investigations, giving continuous attention to the interdependence of both systems. A new vista is opened here, which Freud's genius, moreover, had foreseen. I am not underestimating the enormous difficulties of this task, having myself tried to work out a plan of research along such lines with Benassy. However, I believe that our future investigations will have to go mainly in this direction.

Also from this same point of view, I have tried to determine and point out the effects which result from inadequately integrated aggression and particularly from the fear engendered by it. Fear (anxiety, apprehensiveness or tension produced by insecurity) represents perhaps the most tangible instance of transition from the psychic to the somatic level that we are able to discern. It is active in the human being at every point in his development, when the structure of the ego is still beginning to be formed as well as later in the manifestation of its functions.

In the light of the latest physiological findings it seems likely to me that fear, acting as "aggressor" (Selye), may produce:

(1) an excitation of the hypophysis and hypothalamus, leading to an increase or decrease in intensity of the drives, with all the consequences this implies on the psychic level;

(2) as a result, a reactive upheaval following the line cortex-grey nuclei-hypophysis-sympathetic system, and—since these are probably the physiological sites of the integrative and controlling processes which we attach to the ego—disturbances of the functions of the ego.

Some first support for this hypothesis can be seen in certain aftereffects of epidemic encephalitis, which include clinical manifestations of anxiety and impulses (particularly of an aggressive type), characteristically "uncontrolled" ("as though there were no ego"), as well as subcortical neurological lesions, especially of the grey nuclei.

If fear, more than any other psychic tension, can cause a disturbance in this neuroendocrine system which we believe may contain the somatic sites of the ego functions, the question arises whether the interdependence of these factors might not, to a certain extent, involve their possible reversibility. In the course of psychoanalytic treatment the patient sustains a series of emotional shocks in

the transference situation. These shocks, which can be compared to what Selye calls the "aggressor elements," result in adaptive reactions of the ego. In a continuous and subtle interplay of repercussions and reactions, a process takes place that eventually succeeds in structuring and stabilizing the functions of the ego and in modifying the person's total, physiological make-up. One might ask whether perhaps an analogous process takes place naturally in the child, from the time when the functions of the ego become necessary to him.

Before concluding I should like to apologize for having deviated somewhat from the exact theme of our discussions. But I thought it important to recall that it is necessary to clarify and simplify our ideas in relation to phenomena that are themselves complex in the extreme, in order to be able to handle these ideas properly.

I consider it indispensable to call attention to certain dangers of 'byzantinism' which threaten our psychoanalytic thinking. Without wishing in the least to deny the intrinsic value of certain current works, one cannot but note with regret their purely speculative aspects. Psychoanalysis has nothing to gain from these exegetic elaborations in which the letter always takes precedence of the spirit.

Our essential task is not to push always further in our investigations or to produce something new at any price, but rather, and more simply, to try to see more correctly and more clearly. The way in which we approach the problems that concern us must ultimately be determined from the point of view of effectiveness. And however interesting Hartmann's considerations as to the inter-systemic and intrasystemic complexities may be, it is difficult to see what value they can have in application.

The same might be said of the proposal to revise our conception of reality by shading it according to a given environment or period according to cultural and social conditions and to their influence, in particular on the functions of the ego. All this is perfectly valid in principle but when one sees the complete dissipation of fundamental psychoanalytic concepts to which such tendencies have led, for example, in the works of Karen Horney, one wonders what benefits could result from it. Thus one arrives at the conclusion that it is at best useless to burden the idea of reality with the diverse forms under which it may appear, and that it is sufficient—I should even say preferable—to conceive of it in the classic sense, i.e. as a principle. The rest concerns the sociologists just as the innumerable and complex forms by which the ego expresses itself in the personality concern the psychologists. (I am referring here to sociologists and psychologists who are trained in the psychoanalytic methods and who apply them in their work.)

As for us we shall take the best course if we continue, as in the past to further sociology and general psychology by providing them with firm foundations. But do not let us trespass upon domains where we can only lose our way or squander our strength. Our field of action will be quite vast enough if we abide by what should be our primary task: to seek and to grasp whatever essentially underlies the manifold forms and conditions and thus to attain to the very heart of their moving principle.

W CLIFFORD M SCOTT, M D (London)

The interrelated topics of instinct ego and reality need to be reviewed continuously I think our Executive has done well to arrange this symposium but I think it might go further and suggest to local Societies that they might review this symposium with the hope that further clarification of our present difficulties and confusions could be effected The difficulties which might be clarified by group discussions are only part of our troubles After reading Hartmann's and Hoffer's contributions I feel that our persisting semantic difficulties can be worked with worked through and overcome rapidly The synthetic, discriminating and controlling functions both with regard to instinct and external reality from the time of preambivalence through ambivalent to multivalent relations can be described in greater and greater detail as our experience increases but we must remember that there is more than one way of saying the same thing and that when we try to say something new we should be very clear as to whether we are introducing a new discrimination or whether we only like words and are introducing a synonym

In discussion one has the privilege of being free in making suggestions The first suggestion I make is that too little has been said about consciousness We should not forget Freud's repeated statement that the road to the unconscious was through consciousness The one function of the ego—namely consciousness—which can be related to progression (in contrast to regression) might if considered in more detail lead to further understanding of its relation to the id and external reality I think that this suggestion is the counterpart of Hoffer's suggestions regarding the origin of early inhibition and delay

Hoffer's picture of the matrix of animal instinct out of which the ego and id differentiate seems to me to leave out Freud's earliest hypothesis regarding the origin of the ego namely that it arises out of contact between the id and the external world We recurrently meet the fantasy or fact of withdrawal to deny contact with the outer world and often such fantasy or fact turns out I think to be an example of displacement or introjection In contrast regression is a different mechanism from either displacement or introjection and the hypothesis of regression to an early state of primary narcissism has been for decades most useful But we are apt to forget that one of the ways science has progressed has been by trying to prove the falsity of each hypothesis brought forward Klein's attempts to disprove the hypothesis of primary narcissism is an example and under the stimulus of her work, many psychoanalysts have presented new and detailed hypotheses of different aspects of early ego states But her success in this field led her to the opposite hypothesis—namely that unconscious relationships exist from the earliest ages Here Occam's razor might be brought in—or one might try to disprove this hypothesis of very early object relationships by more detailed observations of memories of infantile states New observations might enable us to describe more in adult regressions Observations of regres-

sive moments or early memories in adults certainly can stimulate us to see more in children's behavior. I am convinced that much of what was once considered primary narcissism is susceptible of analysis in terms of object relationships. Such object relations seem to be between an early ego which are neither stably internal nor external. Such an early ego is so often split (gone to pieces fragmented disintegrated) that it can only be described (but inadequately) in some such terms. With fragmentation stability of internalization and externalization disappears. Fragmentation appears to be dynamic and not regressive to a pre-integrated state of ego nuclei such as Glover² proposed. I was stimulated very much by his article at the time it was written but I have found no evidence to substantiate it and know of no one else who has Splitting fragmentation etc. as mechanisms need to be clarified semantically and clinically.

This brings us to the problem of the different ways the death instinct is formulated in theory and more importantly to the way in which it is interpreted in therapy. Psychoanalysts have already begun to study sleep and in fancy in more detail. Eventually we will have to study old age and dying in more detail to test the death instinct adequately. The maturation of the life instinct continues past the development of genitality. Some of the ego problems of menstruation, infertility and disturbance of parturition and breast feeding may be connected with instinct maturation and may not just be due to the vicissitudes of the earliest partial instincts. Similarly death instinct may show its maturational aspects in old age if we search.

The step from the id impulse to the psychic wish in earliest development has been mentioned both by Hartmann and Hoffer. They both pose the question of what mechanism is used for the first inhibition and Hoffer elaborates the concept of negative hallucination. I think there is evidence available that one of the earliest mechanisms of inhibition is sleep actual or hallucinated. We must ask ourselves the question: what is a total or partial hallucination of sleep and how can hallucinosis of sleep be used as a regressive defense? We need not assume that sleep is only a hybrid state. I think there is evidence that some sleep is aggressive. Some states of stupor may be allied to such aggressive sleep. Lewin³ has discussed connections between sleep and depressive manic stupors but has not suggested that the sleep might be aggressive. The clinical evidence lies in memories or repetitions of sleep which begin suddenly in anger. The aggressive content—the blank pain or silent catastrophic chaos can not easily be separated into dream sleep or hallucinated sleep. These phenomena may be allied to the silent infantile helplessness mentioned by Hoffer.

We should be able to agree about the aim of sleep—is it to stay asleep forever or is it to awake? Some instincts can be satisfied in sleep—e.g. breathing—and we should watch to see whether there is (a) frustration of breathing or (b) hypercathexis of breathing when altered breathing and decreased depth of sleep

² *J Ment Sci* LXXVIII 1932

³ *Psychoanalysis of Elation* New York W W Norton 1950 London Hogarth Press 1951

occur. Similarly we should observe in more detail oral, anal and penile movements in infancy during or before waking.

Hoffer spoke of the "making of objects" and states that the body is "made" as the first object. This making of the body as an object to the psyche may be secondary. Does it not occur after the projection inward from the body surface, as described by Freud in *The Ego and the Id*?⁴ Patients both early and late in analysis may show marked differences in the nearness of the superficies of their psychic apparatus to their body surface. In other words, there is great variation in the division between body surface and psyche and, until we know much more about normality, we will not be near to saying the last word about this problem. Hoffer's statement that ". . . no environment exists until the self as a 'me-experience' has come into being. . . ." needs elaboration. This statement might be taken as a denial of the ego being primarily a structure of *contact* and ego functions being primarily functions of *contact*. In my experience the origin of the mechanisms of introjection and projection and the break-up of primary narcissism into ego and object have seemed to be contemporaneous.

When we are tempted to hypothesize an early absence of any organized synthesizing integrating agency we must remember the lessons of biological observations. We are apt to take behavior as unorganized, unsynthesized, unintegrated by one method of observation when by another it is not so. Also what we may call unorganized, etc., may be similar to what neurologists call a catastrophic reaction in later life—the difference being that in the infant we know so much less of the organized state which is being disorganized. Coghill's⁵ and Goldstein's⁶ work is very applicable to these problems.

Unaided vision used in observing the very young infant may fail to obtain the information which can be obtained otherwise. Discoveries have been made in biology and other sciences both when fast movies have been taken and slowed down for viewing and when a series of stills have been taken and later shown as a movie. This method has not to my knowledge been applied to infants, except to analyze the startle pattern and the Moro reflex.⁷ Unfortunately, this method cannot be used for movements which are noisy and we know, of course, that noise is an important part of orality from an early age. Sound cannot be slowed or speeded without distortion. In observing early sound an adult with special talents in aural discrimination and memory will have to be used in research.

In some memories of early experience the mixture of environmental data and motor and sensory experiences is such that no discrimination can be made between the environmental aspect and the somatic aspect. Such memories can truly be called narcissistic. In the description of such memories many difficulties arise. The outer world of adulthood usually seems more continuous with that of

⁴ (1923) London: Hogarth Press, 1927.

⁵ Herrick, C. J., *George Ellet Coghill*. London: Cambridge University Press, 1919.

⁶ *The Organism*. New York: American Book Co., 1939.

⁷ Landis, C. and Hunt, W. A., *The Startle Pattern*. New York: Farrar and Rinehart, 1939.

infancy than do the motor and sensory experiences—e.g., the memory of the sight and feeling of a rattle used in infancy can be described more easily than the seemingly impulsive erratic movements and sensations connected with the rattle for which the adult has no words. For instance a physician patient used words usually used in describing deterioration of movements to describe such infantile movements. Such movements were not for him when a child ego-dystonic. They were a step to what would later be more persistently controlled movements but would remain something valuable in their own right and would play a part in certain adult movements such as the dance.

Middlemore⁸ and Balint's⁹ observations have stimulated me and I am sure helped me to help a patient reach the point in analysis to be described briefly.

A married woman of twenty five came to analysis as she wanted a child. She was frigid unless during coitus it was possible for her to imagine in her head many couples in various types of coitus. She moved about a great deal and met many people. Social relationships to men and women lasted only a short time. In the fourth year of analysis when near term with her third child she developed an activity plus fantasy with lips and jaws closed (her teeth were felt to be in the way) in which her tongue moved about behind her closed teeth on the roof of her mouth very actively and fast. At the same time feelings progressed downward to gullet stomach bowel bladder and vagina. The fantasies concerned the breast and nipple she had never had. She had been a premature baby and had been fed from a dropper. Not until several weeks old had she had an object on which to suck.

Such experiences have to be understood partly as regression partly as the recovery of unconscious memories (in the sense that such an experience might under different circumstances have become active at an earlier time in her life) and partly as a new aspect of ego development in which oral stomach bowel bladder and genital activities and feelings were integrated.

In 1923 Freud introduced his essay *The Ego and the Id* by saying that he would try to make his thoughts synthetic rather than speculative. Facts had accumulated in the previous thirty years which needed synthesis and his essay contains an outline which is invaluable. When we try to add to this synthesis facts which have accumulated during the thirty years which have elapsed since then we cannot afford to neglect any suggestion made by Freud. Nevertheless to say that his essay is unspeculative is almost an example of British understatement.

Freud wrote that the body itself and above all its surface namely the place from which both external and internal perceptions spring is the basis of the ego. He said that the ego is first and foremost a body ego but it is not merely a surface entity as it soon becomes the projection of a surface. Although the ego

⁸ *The Nursing Couple* London Ham sh Hamilton Medical Books 1911

⁹ Balint M., *J Genet Psychol* LXVIII

is ultimately derived from bodily sensations, chiefly from those springing from the surface of the body, it soon comes to be regarded as the mental projection of the surface of the body. In other words, the "body *imago*" or 'body image' is soon a basic aspect of the ego. Freud used the word projection to mean displacement inward. Had he been writing now he might rather have written about the introjection of a surface to form an *imago* or image of the body.

Hoffer quoted another statement where Freud related this same view to what happens in severe organic pain when the remainder of the ego is emptied or decathected and the painful organ is hypercathected. Freud hypothesized the possibility of a hypercathexis of the psychical representative of the part of the body which is in pain as an alternative to or as a defense against pain in the disordered organ. I think another example of this is seen in the person who hypercathects the phantom limb before admitting amputation. For a time such a hypercathexis may result in the person remaining unconscious of the amputation. It was just such aspects of the ego problem that led me to suggest a new technical meaning to the term "*body scheme*"¹⁰ I suggested using *body-scheme* to refer to the totality when primary narcissism is overcome. The *body imago* or the *body image*, on the one hand, and the *immanent body* with its exterior, interior and surface, on the other hand, each enter into every postnarcissistic situation. Nevertheless just as there is a problem of background in the recurrent regressions to sleep there is also the problem in dreams and awakedness of some synthesis although it may take many forms. Unless in our clinical work we distinguish between the *body imago* or *body image*, the *immanent body* and the *body scheme*, we do less than justice to our material.

Hoffer reminded us that sleep is the earliest narcissistic state. I think he might have said more and suggested that early and late primary narcissism need to be distinguished. If sleep is the earliest stage of primary narcissism—then consciousness of lip, tongue, jaw, saliva, nipple, breast and milk without discrimination is a later stage. Is there not a difference between unconscious primary narcissism which can never become conscious (primary sleep) and conscious primary narcissism which may be to some degree repeated in consciousness in analysis?

We may measure ego activity partly by its awakedness and we may seek ways of measuring this quantitatively, both in terms of levels and in terms of duration. Perhaps Hartmann would consider individual variations in the duration of sleep necessary (or its opposite—the amount of wakedness possible) an autonomous function of the ego. It is surprising that analysts have paid so much attention to sleep dreams and so little to sleep itself.

We must also study memory to discriminate the stages of its development. For the infant to remember an object—e.g., a bottle—is one step but to remember it as a continuing object and not one of a class of objects is another. It is still a third step to develop an ambivalent relationship to an object. The illustration I use to students to show the implications of this in adulthood is what I call the "egg image." When a person imagines, remembers or thinks of an egg

he does not think of it as being the only egg in the world, but he does think of it as being a good egg or a bad egg and he thinks of liking a good egg and hating a bad egg. This can be compared to a preambivalent memory—i.e., recognition without full ambivalence. Full ambivalence can be described as arising when the egg becomes the one and only egg, and is not expendable, but lasting and continuous. The question we must answer is "when memory or primary hallucinosis first occurs, is it multiple or single?" In other words "is a class of similar objects remembered or hallucinated before a single object or vice versa?"

We should be able to agree more about the names for our hypotheses of primary states. Freud wrote about primary process, Brierley¹¹ about feeling and sensory awareness, Isaacs¹² about primary fantasy and Hoffer writes about fusion of sensory and affect awareness. Here differences of opinion partly concern the question of primary fusion and later defusion or primary process and later discrimination and our theoretical views will affect our interpretation. I believe that some analysts interpret states of fusion and others narcissistic states of lack of discrimination when patients present similar primitive material. What we need is material presented in more detail to illustrate our hypotheses.

Summary In trying to write more clearly about ego structure and function we have to clarify our way of talking about instincts and about reality. We have continued to talk of the ego as the structure between instincts and reality. We talk of ego functions as those which make contacts between instinct and reality. I think we should reduce the terms we use to the smallest number possible. When different terms are used it is often unclear as to whether the author is trying to make a distinction or not. We say the ego functions (a) by organizing, synthesizing or integrating (is not synthesis the best term), (b) by dominating, controlling with strength or weakness, (1) movement in regard to all inside and outside the body boundary, and (2) perception of the inner and outer world, (c) by developing defenses against excessive stimuli from within or without by inhibition or by delay, (d) by developing danger signals (in connection with delay and signal formation impulse progressively becomes "wish," "hope," "wonder if," etc., all these being degrees of postponement), and (e) by obtaining gratification, testing reality, developing realization, methods of insight, judgment, etc., and by developing criteria of objective knowledge.

In clarifying the details of such concepts we will clarify the basic concepts of metapsychology. We will do much to stimulate general psychology—both genetic and systematic. We will stimulate therapeutic and preventative measures and we will stimulate our relations with many other disciplines.

¹¹ *Trends in Psycho Analysis* London Hogarth Press, 1951

¹² *Int. J. Psch.*, XXIX, 1948

H G VAN DER WAALS, M D (Amsterdam)

Freud has preserved for us Charcot's magistral words spoken by the latter in reply to the reproach that his clinical findings could not be right, because they were in contradiction with a theory current at that time. Charcot answered 'La théorie, c'est bon, mais ça n'empêche pas d'exister'. I was reminded of these words of Charcot's and of the impression they made upon Freud, when I became absorbed in the papers of Hartmann and Hoffer. I found a great deal in both papers, with which I could wholeheartedly agree, I am indebted to both of them for new insight, but yet I cannot deny that I remain somewhat unsatisfied by both of them as regards the theme under discussion.

Lack of sufficient empirical material as pointed out by both speakers, caused them to keep their treating of the problem to a great extent at least, at a theoretical-speculative level deducing as they were from psychoanalytical theory.

When reading Hartmann's and Hoffer's contributions I become aware of the fact that I am viewing the significance of psychoanalytic theory in a light that seems to be slightly different from their way of thinking. I am by no means inclined to deny the value of psychoanalytic theory in its principal traits but nevertheless I feel often bound to point out that psychoanalysis as an empirical method is richer and provides us with a deeper insight into human reality than the psychoanalytic theory sometimes would let us suspect. Briefly, it is my contention that we should always keep in mind the relative value of many of our concepts. It seems possible that I should give a small contribution toward this discussion when I am illustrating this conviction referring to objections raised in me by today's topic of discussion.

Distinguishing between the three provinces in the psychic personality appears to be a clear and uncomplicated matter, which is undoubtedly of advantage in the description of numerous psychic phenomena. However, it ceases to be so clear and uncomplicated, when we go further into the problem of the delimitation of these provinces. I will confine myself to the ego-id delimitation. In my opinion Hartmann is right in stating—following up a remark of Freud's—that in the early part of psychic life we are not dealing with an id, but with an undifferentiated ego-id; consequently he speaks of the "undifferentiated phase" preceding ego differentiation. The primary process is obviously the primitive way of psychic functioning of this archaic forerunner of the psychic personality, the undifferentiated ego-id. When asking ourselves to which of the two aspects of this undifferentiated phase the primary process belongs to the id aspect or to the ego aspect, it seems probable that the primary process is the way of psychic functioning characterizing the ego aspect of the undifferentiated phase.

Does the ego really originate from the id, is it created by the id? I cannot see that these questions are very important. I for my part am convinced that the foundations of the ego have been given in the undifferentiated ego-id from the outset, the principal features of its development have been established

from the beginning. What Hartmann describes as primary autonomy seems quite right in my opinion.

If my view is correct, the undifferentiated ego-id phase, controlling the early part of psychic life, does not become psychologically significant to us until the child experiences something in it. Hoffer quotes in this connection Brierley's formulation, who designated experience in the state of the undifferentiated phase as 'a fusion of sensory and affect awareness'. This formulation seems to me to be a very good one. From this point I should like to put a question to Hoffer, who says 'that no environment exists until the self as a 'me experience' has come into existence'. Does he not believe that this fusion of sensory and affect awareness is already experienced with a "me" character, even though the child is, at this time, still completely lacking in the cognitive possibilities of distinguishing himself from the outer world, of differentiating a self from a non self and of objectivating it?

Both speakers have been very brief on the development of the id. Hoffer holds that the developmental aspect of the id does not reach beyond that of the development from pregenitality to genitality. Hartmann points out that ego development follows in several respects the lead of the drives. I cannot fully agree with the limited vision of Hoffer as regards the fundamental problems of the id, although I may use the term "development" in a slightly different sense. For the first years of the child's development result in the coming into existence of that portion of the id, which is called the 'repressed' one, almost the only part of the id that we know fairly well. The introduction of the concept of 'id' may have had the drawback that the cardinal significance of the repressed unconscious was slightly overshadowed. As regards the repressed unconscious, the relationship between id and ego is the reverse of the one commonly accepted. Nunberg says that the id has created its ego, but one might state with an even greater certainty, that the repressed unconscious is created by the ego in its successive developmental stages. Conversely, it is of course quite certain that the repressed unconscious is of paramount importance for the course of ego development.

A few moments ago I permitted myself to question whether the introduction of the concept of the id has been profitable in every respect. I will further elaborate this doubt. *Ex definitione*, the id is an agency that does not possess any knowledge of the external world and does not keep any direct contact with the outer world. These occur exclusively via the ego. When strictly adhering to this definition, I must state that I have never found a pure id tendency or impulse in my patients. I have a vivid recollection of the reaction of a colleague, who is somewhat hot tempered, when I ventured to make this unorthodox remark. He flushed with annoyance and snarled that it was undoubtedly an id tendency, if e.g., a patient has the repressed wish or impulse to kill his father. I was not convinced by his objection, because the id does not know anything of an outer world, it does not know that there exist people in this outer world, that one of them is the father, that there exist dead and living varieties of fathers, and that a living father can be submitted to a treatment that changes

H. G. VAN DER WAALS, M.D. (Amsterdam)

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from the beginning What Hartmann describes as primary autonomy seems quite right in my opinion

If my view is correct, the undifferentiated ego-id phase, controlling the early part of psychic life, does not become psychologically significant to us until the child experiences something in it Hoffer quotes in this connection Brierley's formulation, who designated experience in the state of the undifferentiated phase as 'a fusion of sensory and affect awareness' This formulation seems to me to be a very good one From this point I should like to put a question to Hoffer, who says, 'that no environment exists until the self as a 'me experience' has come into existence' Does he not believe that this "fusion of sensory and affect awareness" is already experienced with a "me" character, even though the child is, at this time, still completely lacking in the cognitive possibilities of distinguishing himself from the outer world, of differentiating a self from a non self and of objectivating it

Both speakers have been very brief on the development of the id Hoffer holds that the developmental aspect of the id does not reach beyond that of the development from pregenitality to genitality Hartmann points out that ego development follows in several respects the lead of the drives I cannot fully agree with the limited vision of Hoffer as regards the fundamental problems of the id, although I may use the term 'development' in a slightly different sense For the first years of the child's development result in the coming into existence of that portion of the id, which is called the "repressed" one, almost the only part of the id that we know fairly well The introduction of the concept of 'id' may have had the drawback that the cardinal significance of the repressed unconscious was slightly overshadowed As regards the repressed unconscious, the relationship between id and ego is the reverse of the one commonly accepted Nunberg says that the id has created its ego, but one might state, with an even greater certainty, that the repressed unconscious is created by the ego in its successive developmental stages Conversely, it is of course quite certain that the repressed unconscious is of paramount importance for the course of ego development

A few moments ago I permitted myself to question whether the introduction of the concept of the id has been profitable in every respect I will further elaborate this doubt. *Ex definitione*, the id is an agency that does not possess any knowledge of the external world and does not keep any direct contact with the outer world These occur exclusively via the ego When strictly adhering to this definition, I must state that I have never found a pure id tendency or impulse in my patients I have a vivid recollection of the reaction of a colleague, who is somewhat hot tempered, when I ventured to make this unorthodox remark. He flushed with annoyance and snarled that it was undoubtedly an id tendency, if e.g., a patient has the repressed wish or impulse to kill his father I was not convinced by his objection, because the id does not know anything of an outer world, it does not know that there exist people in this outer world that one of them is the father, that there exist dead and living varieties of fathers and that a living father can be submitted to a treatment that changes

him into a dead one. The repressed unconscious thus appears to possess a fairly accurate knowledge of reality and the possibilities existing in it. *Ex definitione* such knowledge is the exclusive due of the ego. This leads us to another point. If we meet with such a repressed wish in a patient, defense is not the only relation maintained by his ego with this wish or impulse. He actually wards off the portion of the ego, that would draw satisfaction from a fulfillment of this wish. It is not a wish that crops up somewhere in the id, it is his wish he is warding off. Many years ago Alexander already considered the possibility whether part of the conflicts usually described as id-ego conflicts could be formulated more accurately as conflicts between the actual ego and primitive strongly narcissistic ego nuclei. This consideration of Alexander's I have always kept in mind and I am of the opinion that experience corroborates rather than refutes it.

But then we are forced to take a further step. We would have to conclude that the repressed portion of the id is not pure id, but an ego id, just like the undifferentiated phase in the early part of psychic life.

THE ROLE OF BODILY ILLNESS IN THE MENTAL LIFE OF CHILDREN

By ANNA FREUD, LL.D. (London)

I INTRODUCTION

When trying to evaluate the role of bodily illness in the mental life of children, we find ourselves hampered by the lack of integration in the material at our disposal. With the present day division between professional teaching, nursing, child guidance work, child analysis and pediatrics there is little or no opportunity for the trained worker in one of these fields to function, even in the role of observer, in one of the other services for children.¹ Nursery workers, school teachers and child analysts see nothing of the children under their care when they are ill, while pediatricians and sick nurses lose contact with their young patients when they are healthy. It is only the mothers who have the opportunity to see their children in health, illness, convalescence, deviating from the norm bodily and mentally and returning to it. On the other hand, during severe bodily illness the mother's own emotional upset and her inevitable concentration on bodily matters act as distorting factors and leave little room for objective observation of the child's psychological reactions.

In recent years a number of analytic authors have made attempts to deal with the effects of hospitalization on young children, a series of studies which culminated in a documentary film.² But in the case of these studies the interest of the investigators was directed toward the misery and anxiety which arise invariably when young children are removed from their parents, placed in unfamiliar surroundings and handled and cared for by strangers, hospitalization merely serving as the prototype of a first, short term separation from home. Instructive as these investigations are as a demonstration of separation anxiety and its consequences, they did not produce—nor were meant to do so—additional knowledge concerning reactions to illness and pain in infantile life.

Data are less scarce where the aftereffects of illness are concerned.

¹ A notable pioneer exception from this practice has been established by Dr. Milton J. E. Senn, Departments of Pediatrics and Psychiatry, Yale University School of Medicine, New Haven, Conn.

² See this Volume, pp. 82-94.

When describing the neurotic disorders of their children, parents date back the onset of the trouble frequently to some bodily illness, after which the child appeared to be "different." Mood swings, changes in the relationship to parents and siblings, loss of self-confidence, temper tantrums often appear for the first time during convalescence after a severe illness. Symptoms, such as bed wetting, soiling, feeding and sleeping troubles, school phobias, which had existed and been overcome earlier in life, may reappear. Some children who had been considered brilliant in their intellectual performance before illness, reappear afterward in school comparatively dull and apathetic; others surprise their parents and teachers by emerging from the same experience curiously ripened and matured. It is true that changes of this kind may happen after a period of hospitalization. But it is equally true that they happen as well where hospitalization does not take place, i.e., in children who have remained under the care of their mothers during illness and been nursed at home. When considering the effects of bodily illness on the life of the child, it is important to note that hospitalization is no more than one factor among several other potentially harmful and upsetting influences.

II. THE EFFECTS OF NURSING, MEDICAL AND SURGICAL PROCEDURES

Before we can arrive at a correct assessment of this potentially traumatic experience of illness we have to work our way through the action of a large number of factors which, though they are mere by-products of the situation, are for the child's mind inextricably intermixed with it. The child is unable to distinguish between feelings of suffering caused by the disease inside the body and suffering imposed on him from outside for the sake of curing the disease. He has to submit uncomprehendingly, helplessly and passively to both sets of experiences. In certain instances factors of the latter kind, with their high emotional significance, may even be the decisive ones in causing a child's psychological breakdown during illness, or in determining the aftereffects.

(i) *Change of emotional climate during illness.*—There are few parents who do not, imperceptibly or grossly, change their own attitude to the ill child. There are some parents, with ascetic leanings, who are afraid of over-indulging and thereby "spoiling" the child at such times, and consequently leave him severely alone, to "sleep out" his indisposition with the minimum of fussing. The majority of parents adopt an opposite attitude. The ill child may find himself more loved and fondled than at any other time of his life; for a child of a large family an infectious disease, with consequent isolation from siblings, may be the one

occasion when he is in sole possession of his mother's time and care. The mother, owing to her anxiety for the child's health, may suspend all considerations of discipline and good behavior and indulge the child's wishes to the extreme. Or, on the contrary, in her preoccupation with the child's body, she may forget the most elementary principles of psychological handling which she had applied in times of health. Shocks, forcible feeding or evacuation of the bowels, sudden separations (for hospitalization), deceptions (before operations) count for nothing with her so long as they ensure that her child recovers. The child, on the other hand, reacts to such unexpected handling as to traumatic experiences, feels bewildered by the upsetting of formerly immovable emotional and moral standards or finds himself unable to renounce the incidental emotional gains after recovery.

(1) *The experience of being nursed*—The child's reaction to the experience of being nursed is understood best in terms of comparison with the better known and frequently described reactions of adults to the corresponding situation.³ A normal adult who is nursed through a severe illness cannot help feeling at the same time that he is exposed to a series of indignities. He has to renounce ownership of his own body and permit it to be handled passively. He is dressed and undressed, fed, cleaned, washed, helped with urination and defecation, turned from one side to the other, his nakedness exposed to nurse and doctor, regardless of sex, of decencies and conventional restrictions. He is, as it were, under orders, subjected to a hygienic routine which implies a major disregard for his personal attitudes and preferences. Characteristically enough many adults sum up this experience as being 'treated as a baby,' or as a 'complete return to the conditions of their childhood.'

On the other hand it would be a mistake to conclude from such statements that the situation of being nursed by virtue of its similarity to infantile experiences is less upsetting to the child than to the adult. Observation as well as theoretical considerations show that the opposite may well be the case. The gradual mastering of various bodily functions, such as independent eating, independent bowel and bladder evacuation, the ability to wash, dress, undress, etc., mark for the child highly significant stages in ego development as well as advances in detaching his own body from that of the mother and possessing it at least in part. A loss of these abilities, when occasioned by the nursing procedures (or by the weakened bodily condition itself) means an equivalent loss in ego control—a pull back toward the earlier and more passive levels of infant.

³ Compare in this connection "The Middle of the Journey" by Lionel Trilling with its striking description of an adult intellectual returning to responsibility for his own health after having been looked after and nursed during a severe illness.

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tile development. Some children who have built up strong defenses against passive leanings oppose this enforced regression to the utmost, thereby becoming difficult, intractable patients, others lapse back without much opposition into the state of helpless infancy from which they had so recently emerged. Newly acquired and, for that reason, precariously anchored ego achievements are lost most frequently under these conditions. Many mothers report that after a period of illness their young infants have to be retrained so far as their toilet habits are concerned, weaned once more from spoon feeding, from clinging to the constant company of the mother, etc.

(iii) *Restrictions of movement, diet, etc*—In contrast to the comparative ease with which ego skills and abilities are renounced under the impact of being 'nursed,' children defend their freedom of movement in the same situation to the utmost wherever they are not defeated by the type or intensity of the illness itself. It is well known that at least under the conditions of home nursing, children with minor indispositions can not be kept in bed consistently, or at least not lying down in bed. Young toddlers, who have only recently learned to walk, are known to stand up stubbornly in their beds for the whole course even of severe illnesses (for instance measles) until exhaustion forces them to adopt the lying position.⁴ Recently some enlightened pediatricians have accepted this state of affairs and treat their child patients, whenever possible, without enforcing bed rest.⁵

The psychological significance of the children's negative attitude in this respect becomes apparent in those extreme instances when child patients have to be immobilized after surgery or in the course of orthopedic treatment. Several analytic authors have observed and discussed the consequences of such extreme restraint of movement of limbs and have pointed out the possible connection with the emergence of stereotyped, tic-like movements elsewhere in the body (David Levy, 1928, 1944), the difference of this mechanically enforced from psychologically enforced restraint (Mahler, Luke, Daltroff, 1945), their bearing on the blocking of aggression discharge as well as on the discharge of stimulation in general with consequent overerotization of the whole body (Greenacre, 1944). Thesi Bergmann (1945), in an observational study car

⁴ See in contrast to this the remarks in IV (i) of this paper.

⁵ In England Dr Elsie Wright formerly physician at the Babies Hospital Newcastle on Tyne. Impressed on the members of the Cassel Hospital Summer School for Ward Sisters (1919) that in children's wards there should be "no rigidity about the child being kept in bed." Dr Josefina Stross pediatrician when teaching students of the Hampstead Nurseries (1940-1945) and the Hampstead Child Therapy Course emphasized repeatedly that even where children have to be kept off the floor movement inside the crib should not be restricted.

ried out during three years' work in an orthopedic ward, gives a vivid description of the defense mechanisms which enable the immobilized children to bear the restraint and even to increase their docility when the restraining measures have to be increased. On the other hand she describes the rages and temper tantrums which appear when the restraint is partially, not wholly, lifted or when chance deprivations, outside the expected medical procedure, are added to it unexpectedly. She emphasizes, further, a twofold relationship between the immobilized limbs and other parts of the body. According to her experience, on the one hand the restraint of one limb may spread in the form of inhibitions to other, nonaffected parts; on the other hand certain ego skills, speech, etc., may undergo an accelerated development to compensate for motor restriction of one limb. The same processes as they occur in children with pulmonary tuberculosis are presented in a highly interesting study by Sara Dubo (1950).

These authors' observations are confirmed by much nonrecorded experience of parents and teachers. The heightening of aggression during and after motor restraint (in plaster casts, etc.) is especially well known to the general public. The most usual ways in which this dammed-up aggression appears are restlessness, heightened irritability, the use of bad language, etc.⁶

In comparison with this massive blocking of a whole system of discharge, the food restrictions imposed on children during illness are of minor importance. Normally, in acute illnesses, the physiological lessening of the child's appetite prepares the way for the acceptance of a reduced diet; it is only the children with strong oral fixations, for whom food and deprivation of food have heightened libidinal significance, who react to the situation with fantasies of being badly treated, unloved, rejected. In chronic illnesses (such as diabetes, kidney trouble, colitis, allergies) where dietary restrictions have to be maintained for long periods of time, children are known to feel "different," singled out, discriminated against, or, in defense against being passively deprived, to develop ascetic self-denying tendencies.

On the whole, considerably less harm is done by the necessity of withholding desired foods than by an anxious mother, urging or even forcing unwelcome food on an ill child. It is these latter situations which turn even minor, short illnesses into starting points for serious and prolonged

⁶ The present author has analytic knowledge of a girl who was immobilized during her latency period for orthopedic reasons. She used to pay her friends out of her pocket money for every new swear word which they brought home from school. The use of "bad language" was the only outlet left for her otherwise paralyzed aggression.

eating difficulties, usually by reviving feeding battles which have raged between mother and child in the nursing period.

For some children the taking of medicines presents a major difficulty. Though the bad taste or smell of the drug is in the foreground so far as the child's conscious reasons are concerned, analytic investigation discloses invariably behind these rationalizations the existence of repressed ideas of being attacked by the mother through the symbol of the drug (Melanie Klein), of being poisoned, impregnated, by her. Laxatives which force the bowels to move, though the child intends otherwise, may form the connecting link between reality and these unconscious fantasies.

In this connection it is interesting to remember that the punitive character of these restrictive measures has always been known to parents and has been exploited by them. To send a child to bed, confine him to his room, deprive him of favorite dishes have been used as punishments over the ages. In certain societies even the forcible administration of laxatives is used for the same purpose.

(iv) *Operations*.—Ever since the discovery of the castration complex analysts have had ample opportunity in their therapeutic work to study the impact of surgical operations on normal and abnormal development. By now it is common knowledge among analysts that any surgical interference with the child's body may serve as a focal point for the activation, reactivation, grouping and rationalization of ideas of being attacked, overwhelmed and (or) castrated. The surgeon's action, from minor surgery to major operations, is interpreted by the child in terms of his level of instinct development, or in regressive terms. What the experience means in his life, therefore, does not depend on the type or seriousness of the operation which has actually been performed, but on the type and depth of the fantasies aroused by it. If, for example, the child's fantasies are concerned with his aggression against the mother projected onto her person, the operation is experienced as a retaliatory attack made by the mother on the inside of the child's body (Melanie Klein); or the operation may be used to represent the child's sadistic conception of what takes place between the parents in intercourse, with the child in the role of the passive sexual partner; or the operation is experienced as mutilation, i.e., as punishment for exhibitionistic desires, for aggressive penis envy, above all for masturbatory practices and oedipal jealousies. If the operation is actually performed on the penis (circumcision, if not carried out shortly after birth), castration fears are aroused whatever the level of libidinal development. In the phallic phase, on the other hand, whatever part of the body is operated on will take over by displacement

the role of an injured genital part.⁷ The actual experience of the operation lends a feeling of reality to the repressed fantasies, thereby multiplying the anxieties connected with them. Apart from the threatening situation in the outer world, this increase of anxiety presents an internal danger which the child's ego has to face. Where the defense mechanisms available at the time are strong enough to master these anxieties, all is well, where they have to be overstrained to integrate the experience, the child reacts to the operation with neurotic outbreaks, where the ego is unable to cope with the anxiety released, the operation becomes a trauma for the child.

In a recent symposium on the Emotional Reactions of Children to Tonsillectomy and Adenoidectomy, a representative group of analysts, psychiatrists, pediatricians and psychologists discussed the subject in the light of these ideas with a view to lessening the traumatic potentialities of the three main factors involved in the situation: reaction to anesthesia to hospitalization and to the operative procedure itself. Finding the optimal time for carrying out an operation (Hendrick, Escalona, Sylvester), careful preparation before the event (Fries, 1946), avoidance of separation anxiety (Jackson 1942), Putnam, Butler), psychiatric support (Rank), facilities for expression of feeling (Spock) were brought forward as the most important precautionary measures (Levy, 1945, Pearson, 1941).

When studying the aftereffects of childhood operations in the analysis of adult patients we find that it is not the castration fear but the feminine castration wish in a male child which is most frequently responsible for serious postoperative breakdowns or permanent postoperative character changes. In these instances the surgical attack on the patient's body acts like a seduction to passivity to which the child either submits with disastrous results for his masculinity, or against which he has to build up permanent pathologically strong defenses.

III PAIN AND ANXIETY

(1) *The mental interpretation of pain*—The manner in which the child invests bodily events with libidinal and aggressive cathexis and significance creates a phenomenon which has baffled many observers. Parents and others who deal with young children comment frequently on

⁷ By deciding on the length of preparation time before an operation two factors have to be taken into account. A preparation period which is too lengthy leaves too much room for the spreading out of id fantasies, where the interval between knowledge and performance of operation is too short the ego has insufficient time for preparing its defenses.

the remarkable individual differences in children's sensitiveness to bodily pain, what is agonizing to one child may be negligible to another. The analytic study of such behavior reveals as different not the actual bodily experience of pain but the degree to which the pain is charged with psychic meaning. Children are apt to ascribe to outside or internalized agencies whatever painful process occurs inside the body or whatever hurt happens to the body (accidental hurts, falls, knocks, cuts, abrasions, surgical interference as discussed above, etc.) Thus, so far as his own interpretation is concerned, the child in pain is a child maltreated, harmed, punished, persecuted, threatened by annihilation. The "tough child" "does not mind pain," not because he feels less or is more courageous in the real sense of the word, but because in his case latent unconscious fantasies are less dominant and therefore less apt to be connected with the pain. Where anxiety derived from fantasy plays a minor or no part, even severe pain is borne well and forgotten quickly. Pain augmented by anxiety on the other hand, even if slight in itself, represents a major event in the child's life and is remembered a long time afterward, the memory being frequently accompanied by phobic defenses against its possible return.

According to the child's interpretation of the event, young children react to pain not only with anxiety but with other affects appropriate to the content of the unconscious fantasies, i.e., on the one hand with anger, rage and revenge feelings, on the other hand with masochistic submission, guilt or depression.

The correctness of these assumptions is borne out by the fact that after analytic therapy formerly oversensitive children become more impervious to the effect of pain.

(11) *Pain and anxiety in infants*—Where the direct observation of infants in the first year of life is concerned, the relative proportion of physiological and psychological elements in the experience of pain is an open question. At this stage any tension, need or frustration is probably felt as 'pain,' no real distinction being made yet between the diffuse experience of discomfort and the sharper and more circumscribed one of real pain arising from specific sources. In the first months of life the threshold of resistance against stimulation is low and painful sensations assume quickly the dignity of traumatic events. The actual response of the infant, whether it occurs instantaneously, or after a time lag of varying length, or remains invisible altogether, is no reliable guide to an assessment of the shock caused by the pain.

From what age onward the bodily event is supposed to carry psychic meaning for the infant will depend altogether on the analytic observer's

theoretical assumptions concerning the date when unconscious fantasies begin to exist

For the observer of children under the conditions of medical treatment it is interesting to note that older infants (two to three years) may react with almost identical distress to the experience of injections or inoculations and to the experience of sunlight treatment, although the former involves pain (plus anxiety) whereas the latter is merely anxiety raising without any pain involved

(iii) *Passive devotion to the doctor*—It is the psychological meaning of pain which explains why doctors, and other inflictors of pain, are not merely feared but in many cases highly regarded and loved by the child. The infliction of pain calls forth passive masochistic responses which hold an important place in the child's love life. Frequently the devotion of the child to doctor or nurse becomes very marked on the days after the distress caused by a painful medical procedure has been experienced

(iv) *Reaction to pain as a diagnostic factor*—With young boys in the oedipal stage, their reaction to bodily pain provides a useful key to the differential diagnosis between genuine phallic masculinity and the misleading manifestations of reactive overstressed phallic behavior designed to ward off passive feminine castration ideas. The masculine boy is contemptuous of bodily pain which means little to him. The boy who has to defend himself against passive leanings cannot tolerate even slight amounts of pain without major distress

IV THE EFFECTS OF ILLNESS

(i) *Changes in libido distribution*—The casual observer, while following with his attention the loud, manifest reactions to anxiety and pain, nursing procedures and restrictions, is in danger of disregarding another process which silent and under the surface, is responsible for most important alterations during illness: i.e., the heightened demand of the ill body for libidinal cathexis. Some observant mothers know the mental signs heralding this state and are able to diagnose from them the onset of a disease even before any significant bodily symptoms have appeared

There are two ways for the patient to react to this demand from the side of the body. Many children who, when healthy, are in good contact with their surroundings, full of interest in their toys and occupations and in the happenings of everyday life, begin their sicknesses by withdrawing from the environment, lying down on the floor or curling up in a corner, listless and bored.⁸ At the height of the illness they lie in bed

⁸ This refers to cases where such listlessness cannot be accounted for on physiological grounds

without moving, their faces turned to the wall, refusing toys, food as well as any affectionate advances made to them. Though these reactions occur in certain children regularly, even with harmless sore throats, stomach upsets, raised temperatures, and the most common infectious children's diseases, the impression given by such a child in a state of withdrawal is that of a seriously ill person. Anxious mothers are terrified by this complete reversal in their child's behavior and feel him to be in grave danger. In reality the manifestation is not a physiological but a psychological one and not commensurate with the severity of the illness. It is a change in libido distribution during which cathexis is withdrawn from the object world and concentrated on the body and its needs. Despite its frightening suggestion of malignancy this process is a beneficial one, serving the purpose of recovery.

There are other children who, for some unknown reason rooted in their individual libido economy, use a different manner to achieve the same result. Unable to give their own ill body the additional narcissistic cathexis which it demands from them, they claim this surplus of love and attention from the mothers who nurse them through the illness, i.e., they become demanding, exacting, clinging far beyond their years. In doing so they make use of a natural process dating back to the first year of life, when the mother's libidinal cathexis of the infant's body is the main influence in protecting it from harm, destruction and self injury (Hoffer, 1950). For the surface observer children of this type are extremely 'fussy' when ill, those of the former type are undemanding.

In both cases the gradual return to health is accompanied by a gradual regularization of these movements of libido, though not without difficulties and reversals during which the child appears "cranky." Occasionally the abnormal distribution of libido proves irreversible for a certain length of time and produces some of the puzzling personality changes after illness which have been pointed out above.

(11) *The child's body as the mother's property* *Hypochondria*—Some mothers find it difficult to resign themselves to the fact that their children, even after the toddler stage, cannot really be trusted to take care of their own bodies and to observe the rules serving health and hygiene. When ever a mother reports with pride that her child washes hands before eating without being told to do so, analytic exploration will reveal that the child in question is a severe obsessional and his apparently sensible cleanliness a compulsive and magical defense against imaginary, dangerous contact. Children who protect themselves against colds and drafts ward off fears of death, those who choose their foods carefully do so on the basis of fears of being poisoned, those who refrain from eating too much or too many nourishing foods are obsessed by anxieties concerning

pregnancy The average, normal child will observe none of these precautionary measures, he will eat with dirty hands, stuff himself, brave wet and cold weather, eat green apples and other unripe fruits unless forced, urged or prevented by his mother In illness he will at best cooperate with her, at worst he will fight the care taken of him and proceed to use his own body as he pleases So far as health, hygiene and the nursing care are concerned, the mother's ownership of the child's body extends from earliest infancy, when the mother child unity is an important factor in the libido economy of both, through all the phases of childhood into adolescence At this last stage, before independence is finally reached, recklessness in matters of health provides one of the familiar battle grounds for bitter struggles between the adolescent and his mother

It is interesting to observe that this state of affairs is reversed more or less completely where motherless, orphaned and institutional children are concerned, even in those cases where competent professional nursing care is provided Far from enjoying the freedom from anxious motherly supervision (as the observer might expect from the mothered child's revolt against her care) motherless children proceed to care for their own bodies in an unexpected manner In an institution known to the author it was difficult sometimes to prevail upon a child to shed his sweater or overcoat in hot weather, his answer was that he 'might catch cold' Rubber boots and galoshes were asked for and conscientiously worn by others so as 'not to get their feet wet' Some children watched the length of their sleep anxiously, others the adequacy of their food The impression gained was that all the bogeys concerning the child's health which had troubled their mothers' minds in the past had been taken over by the young children themselves after separation or bereavement, and activated their behavior In identification with the temporarily or permanently lost mother, they substituted themselves for her by perpetuating the bodily care received from her⁹

When watching the behavior of such children toward their bodies we are struck with the similarity of their attitudes to that of the adult hypochondriac, to which perhaps it provides a clue The child actually deprived of a mother's care, adopts the mother's role in health matters, thus playing 'mother and child' with his own body The adult hypochondriac who withdraws cathexis from the object world and places it on his body is in a similar position It is the overcharging of certain body areas with libido (loving care) which makes the ego of the individual

⁹ A most instructive example of this behavior is the instance of a motherless boy of six years who in a long drawn out nightly attack of vomiting and diarrhea was heard to say to himself "I my darling When asked what he meant he answered "That I love myself It is good to love oneself isn't it?"

hypersensitive to any changes which occur in them. With children analytic study seems to make it clear that in the staging of the mother-child relationship, they themselves identify with the lost mother, while the body represents the child (more exactly: the infant in the mother's care). It would be worth investigating whether the hypochondriacal phase which precedes many psychotic disorders corresponds similarly to a regression to and re-establishment of this earliest stage of the mother-child relationship.

V. SUMMARY

In carrying further the author's and other writers' studies of separation anxiety (hospitalization) this paper surveys the other factors which play a part in the child's reaction to bodily illness. The effects of the various nursing, medical and surgical procedures which are open to modification are distinguished from those elements which are inherent in the process of illness itself, such as the effects of pain and the inevitable changes of libido distribution. Lastly, a comparison is drawn between the state of deprived children who care for their bodies in identification with their lost mothers and the adult hypochondriac who over-cathets his body with libido after it has been withdrawn from the object world.

In summarizing these factors which play an important role in every normal development the author wishes once more to stress how serious a measure hospitalization is, separating the child from the rightful owner of his body at the very moment when this body is threatened by dangers from inside as well as from the environment.

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A TWO-YEAR-OLD GOES TO HOSPITAL¹

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BACKGROUND TO STUDY

Originally the separation research was concerned to test the hypothesis that separation experiences are pathogenic, but once the literature had been thoroughly surveyed (Bowlby, 1951) it became clear that this hypothesis is well supported by evidence, and the team is now planning to concentrate on understanding the psychological processes which lead to the grave personality disturbances—severe anxiety conditions and psychopathic personality—which we now know sometimes follow experiences of separation. To achieve this understanding we intend to make detailed records of how very young children respond to the experience of being separated from their mothers. This study was made last August as an experiment in developing techniques of observation and recording.

Laura, the subject of the film, is a child of two years and five months, with, in general, happy relations with both her parents. In emotional development she is advanced for her years and developmentally she falls at the top end of the age group in which we are interested. Although her responses to the experience of separation contain much that we believe to be typical of the age span eighteen to thirty six months, her expression of feeling is far more controlled than is usual. In discussing her responses we shall dwell on those which we believe to be common to this group of children and will not discuss the personal circumstances of this

¹ Paper read by Dr Bowlby at a meeting of the British Psycho Analytical Society on March 5, 1952 after a showing, introduced by Mr Robertson, of an unedited version of the film, *A Two-Year Old Goes To Hospital*, on February 29, 1952. This film was made within the framework of the research on "The Effects on Personality Development of Separation from the Mother in Early Childhood," on which we have been engaged for the last four years at the Tavistock Clinic. The film itself is the work of Mr James Robertson who was the first member of the research team. In the following discussion we shall be drawing on the film data as well as the written record which covers the whole of the child's waking life during her eight-day stay and which is the work jointly of Mr Robertson and Miss Rosenbluth. A brief account of the way the film was made and the sequence of principal events appears in the Appendix to this paper.

child, such for instance as that her mother is five months pregnant. Though obviously very relevant to a complete understanding of this particular child, our various and fragmentary observations on other children suggest that much of what is shown can properly be considered without reference to it.

It should, however, be remarked that this child is confined to a cot and that her responses are undoubtedly affected by this restriction. In general it has been our observation that the responses to separation of children confined to their cots do not differ greatly in quality from those of children not so confined, but that their distressful responses are more intense and show fewer remissions. This is probably due partly to the frustration of movement and partly to the child having no opportunity to distract himself from his distress by play (Levy, 1944) or to discharge aggression through motility.

Among a child's responses after having been separated at this age, the two commonest are (1) an intense clinging to the mother, which can continue for weeks, months or years and, (2) a rejection of the mother as a love object, which may be temporary or permanent. Her permanent rejection though dramatic and extremely serious, is fortunately rare. Our task is to understand how these pathological responses originate and develop. For this reason throughout these studies our observations are concentrated on the child's responses to his love objects, especially his mother. In opening this discussion, therefore, we shall confine our remarks to the course taken over these eight days by Laura's responses to her mother. After giving a brief description of some of the data and attempting a theoretical formulation, we shall make a few remarks about the place of observations of this kind in analytic research. In this paper we shall not discuss what social action should be taken to prevent young children from being submitted to these experiences. That is a matter in which we are deeply involved and to which we attach great importance. In our view, however, it is not possible, in one paper, to discuss both preventive action and psychodynamics and it is our especial wish to confine ourselves to psychodynamics.

DISCUSSION OF LAURA'S RESPONSES

It is our experience that the great majority of children of about eighteen to thirty six months respond to loss of their mothers, such as occurs when a child goes to a residential nursery or hospital, by protesting for the return of their mothers. Laura is no exception as the film shows, she expresses her longing for her mother clearly, directly and very frequently, both in her remarks and in her searching behavior. This phase

of protest, however, never continues indefinitely. Sooner or later, as despair grips the child, a new response gathers momentum—one of denying the need for mother—a response in which repression is playing a large part. Laura never reaches this phase of complete denial, instead, her overt expression of wanting her mother continues actively throughout the eight days and, indeed, dominates her whole world. This maintenance of the need in conscious and overt form throughout the eight days is unusual and, we believe, due, to at least three factors: (1) an initial good relationship with the mother, (2) frequent visiting, and (3) Laura's comparative maturity. But even though the need remains conscious and active, it should be noted that its expression is often muted down in unusual degree. Again and again she mutters, "I want my Mummy" or "I want to go home" in an offhand and incidental way as though it had no significance. Clearly there is repression at work and the full emotional force of the need is being inhibited. There are also occasions when her need for her mother is displaced onto a desire for something else. This is illustrated by her repetition of "I want to see the steamroller—I want to see the steamroller," which she intersperses with "I want to see my Mummy." On another occasion she expressed a desire to go swimming with another little boy in the ward, although it is clear that she really wants to go swimming with her parents. Such inhibition and displacement appear to be more frequent when Laura is alone when a nurse is present the expression of the need is more explicit and direct.

In addition to repression and displacement we are able to observe the need for her mother undergoing a variety of other transformations, any one of which, if developed and consolidated, could, we believe, lead to a serious disturbance of object relations and so of personality. In picking out what we have we are naturally greatly influenced by our observations on other children.

These transformations can be grouped as

- (i) Changes in Laura's response to her mother as a real figure
- (ii) Vicarious expression of her need by means of projective identification.

One of the most striking observations is the contrast between Laura's repeated wishes for her mother to come and her inability to greet her when she did so. At the beginning of each of the four visits there was a time lag before she could make a positive response to her mother, although it was quite clear that on each occasion there was an immediate recognition of her. Her initial response on the first two occasions was different from that on the second two. On the first two occasions she burst into tears when she saw her mother, on the first actually turning

away from her. In each instance there followed an interval of some minutes (about two in the first and as long as ten in the second) before a positive response began to emerge. Once emergent it gathered momentum and led, in the first instance when the nurse restrained her from getting to her mother, to violent and uncontrolled crying (the first she had shown while in the hospital) and in the second to the happy intimate play with her mother which is such a joy to watch on the screen.

During the third and fourth visits there was no initial crying. Instead Laura greeted her mother with a blank expression and made no attempt to get into contact with her. This same caution was shown very dramatically when her mother came to take her home: not until the shoes were produced did she respond. In research on separation we have become very familiar with these blank responses on reunion with the mother. While the overt crying is a response to tension after a brief separation experience, these blank responses occur on reunion with the mother after longer periods of separation, so that their not occurring in the first three or four days is typical.

A very dramatic example of this blank response, though one which is of a much more far reaching character, occurred in the case of Laura four months after the film was taken, when she was two years nine months old. Her mother was in a hospital for four weeks while having the baby and Laura was cared for by her maternal grandmother. During this time she saw neither her mother nor her father, and it was stated that, after some initial fretting, she was 'very happy' (We have, however, no first hand account of Laura's behavior during this time and we suspect the validity of this description). The reunion with her mother began when the mother, who was at home, spoke to Laura on the telephone. Laura was very excited and keen to return home. Half an hour later she arrived and the mother could hear her banging on the outside door and calling "Mummy, Mummy". But when her mother opened the door, *Laura looked at her blankly and said, 'But I want my Mummy'*. For the next two days she did not seem to recognize her mother, and although quite friendly was completely detached. This naturally upset her mother very much. When the father came home an hour or two after Laura's return, Laura was for a few moments mute toward him but then recovered quickly and was friendly and sure of him. He had arranged to begin a holiday that day, and during the subsequent days they were in a very good relationship. As regards her attitude to her mother, the parents had ideas that she might perhaps have lost her memory and they tried her out in various ways to see if she recognized her favorite dolls and household articles which, of course, she did. After two days it is said that her relationship to her mother had completely recovered. There had been

no temper tantrums, no sleeping disturbances, no eating disturbances, but the mother was slightly irritated that quite often when Laura wanted something she addressed her mother as 'Nanna.'

In this incident Laura's *need* for her mother was clearly conscious but for some reason could not be linked to her real mother when seen in the flesh, though oddly enough it was linked to her voice on the telephone. In an attempt to explain the psychodynamics of this process, we offer the hypothesis, which obviously owes much to Mrs Klein, that during the separation experience the image of the real whole mother undergoes changes in both an idealized direction and a depreciated one. On the one hand is the picture of the wholly satisfying mother the child so badly needs and desires, on the other that of the wholly frustrating mother who has deserted the child and caused such acute distress. The image of the real mother is swamped and obliterated by these two contradictory and highly charged images. As a result, when she meets her mother again, Laura fails to recognize her—her mother does not fit either of these maternal pictures. Such splits of love objects into satisfying and frustrating ones occur, of course, regularly in a person's life, as when he falls in love or sulks. In early childhood such splits are usually made good by the continuing experience which the infant or young child has of a real loving mother whose presence constantly corrects the tendency to split. It is no doubt partly because of this psychic tendency to split the mother into an idealized love image and a depreciated hated one that the actual experiences which a child has of a real mother are of such great importance for the development of his personality and why the lack of the continuous care of a real loving mother can be so gravely pathogenic.

Fortunately in Laura's case the splits were corrected. During the hospital experience these splits were relatively brief, after a few minutes of blankness she "came to" and responded to her real mother. This response was predominantly affectionate but on one occasion, when she hit the Teddy whom her mother was holding with the hospital doll, there was evidence of displaced hostility. After the later separation, which lasted four weeks, the split was more serious and it was forty-eight hours before she could discover her mother as a real person—both satisfying and frustrating. This perhaps helps us to understand how during longer experiences of separation this split can develop to a point where integration on reunion with the mother is no longer automatic and the child is unable to link his need for a good mother and his hatred of a frustrating one to an individual woman. This, we believe is what happens in the case of the affectionless and psychopathic character. The two drives—desire for a good object and hatred of the frustrating one—live

on, with their appropriate internalized mother figures, but never are they integrated in a real relationship with a real person

Laura's responses to separation from her father are very different from those to separation from her mother, though the variables are such that it is not easy to know the significance of these differences. In the first place she did not ask for her father throughout the first two days, and when both her parents visited after the operation she cried persistently for her mother, despite her father being nearer to her. She nevertheless held on to her father's tie and on subsequent days asked repeatedly for him. On the other occasion when her father visited, on the seventh day, she greeted him immediately and there was no period of emotional freeze up. This of course, may have been due to her mother having thawed her out by the time the father appeared, but her very different responses to her father and her mother after the baby's birth do not suggest that this is the explanation. To us it seems more probable that the intensity of her need for the father in time of illness is less great and so also is the pain of frustration. In consequence the intensity of the conflicts set up by separation from him is less, with a consequent reduction in the split in internal objects. This enables her to respond to him in a natural way. We have other examples of children who after long separation appear to have repressed all feeling for their mothers but whose relation to their fathers is much less impaired. One such case is a boy, which shows that this response, which might almost be described as an oedipal defense, is not confined to girls.

Before discussing Laura's projective identification, we want to call attention to her use of the two favorite toys she brought with her—her 'Teddy and her 'baby,' as she called her blanket. Throughout the eight days these were her constant companions. She clung to them and cuddled them when she was alone in her cot, just before going to sleep, and also when she felt threatened—as for instance when she was visited by the surgeon. Other casual toys, such as a little bag which her mother brought on one of the visits, were treated similarly. They were clearly part and parcel of her love relationship with her mother—partly identified with herself and partly with her mother—and it was striking how she insisted that every single one of these possessions must return home with her. It is our suspicion that this strong attachment to loved toys would have faded away and been replaced by rejection of them had this child's responses progressed to the phase of denying her need for her mother. This is a matter to which we intend to give special attention in future. Like Dr Winnicott, we believe that these transitional objects afford a specially rich field for research into early object relations.

Laura's maltreatment of the precious hospital doll on the fourth day

(a lively episode in the film) is assumed by us to be a displaced expression of her hostile feelings for her absent mother. It appears (from an analysis of the written record) that expressions of hostility increase as the days pass. Phrases beginning, "I don't like" begin on the third day and are especially frequent from the fifth day onward. Hitting the doll and aggressive banging of doors when she was up are features of the fourth and successive days.

We have already noted that while Laura was able to maintain her desire for her mother in consciousness, it was unusually muted considering her age, and that this indicates some measure of repression. That repression of the frustrated need was in process was also indicated by the occasions when she utilized other children to express her desire for her mother. This began on the first day and continued throughout. She frequently asked, "What's that baby crying for?" and answered her own question with, "He's crying for his Mummy." A little boy of three and one half years who cried persistently and heartbreakingly, she comforted with the remark "Don't cry, don't cry, Mummy's coming tomorrow."

That there was repression of her own desire to cry and a use being made of projective identification is made clear by her remarks "I not crying I not crying seel" and by an incident when she stopped crying herself as soon as the baby in the next cot started to cry.

From other cases we know that a repression of the need for the mother, together with projective identification with others in need and the assumption toward them of a maternal role, is a common character formation in deprived children and often makes them intensely possessive parents. It is our impression, though it requires confirmation, that it occurs more frequently in girls and that it will not develop if the separation takes place before about two years of age. Perhaps it requires a considerable degree of ego and superego development.

In this connection it is worth remarking on the active operation of the superego in this child of two years and five months. We know that she has received repeated injunctions not to cry and we see her heroic and by no means unsuccessful attempts to obey. No doubt this unusual degree of superego development is a result partly of maturation, but maternal pressure has clearly played a large part also. It is our guess that such active superego development at this age does not bode well for her future—we would expect some measure of obsessional character to develop.

Of the many other points which could be discussed, we will select only one—the picking of her cheek and nose which began within two hours of Laura's admission to hospital, continued throughout her stay, and is said by her mother not to have been a characteristic of hers before. It is not easy to know its significance. Anna Freud suggested to us that

some of it may have been connected with her attempts not to cry and to wipe away her tears. It is interesting to compare Laura with two other separated children who developed ticlike movements. One is a child of about three and one half years whom one of us observed playing a repetitive game by himself of a kind which appeared at first sight to be quite happy. He was bowing, turning his head to the left and lifting his arm. This seemed harmless and meaningless enough. When Mr. Robertson approached him, however, he heard him muttering to himself, My Mummy's coming soon—my Mummy's coming soon—my Mummy's coming soon—and he was evidently pointing to the door through which she would enter. This was at least three hours before she could be expected.

The other is a boy of three years two months whom Anna Freud (1943, pp. 99-100) has described in her report of the Hampstead Nursery for March 1941. Prior to admission to the Nursery he had had two previous separations so that he was extremely sensitive to being left again. Like Laura he was admonished to be a good boy and not to cry—otherwise his mother could not visit him.

Patrick tried to keep his promise and was not seen crying. Instead he would nod his head whenever anyone looked at him and assured himself and anybody who cared to listen that his mother would come for him. She would put on his overcoat and would take him home with her again. Whenever a listener seemed to believe him he was satisfied; whenever anybody contradicted him he would burst into violent tears.

This same state of affairs continued through the next two or three days with several additions. The nodding took on a more compulsive and automatic character. My mother will put on my overcoat and take me home again.

Later an ever-growing list of clothes that his mother was supposed to put on him was added. She will put on my overcoat and my leggings; she will zip up the zipper; she will put on my pixie hat.

When the repetitions of this formula became monotonous and endless, somebody asked him whether he could not stop saying it all over again. Again Patrick tried to be the good boy that his mother wanted him to be. He stopped repeating the formula aloud but his moving lips showed that he was saying it over and over to himself.

At the same time he substituted for the spoken words gestures that showed the position of his pixie hat, the putting on of an imaginary coat, the zipping of the zipper, etc. What showed as an expressive movement one day was reduced the next to a mere abortive flicker of his fingers. While the other children were mostly busy with their toys, playing games, making music, etc., Patrick, totally uninterested, would stand somewhere in a corner, move his hands and lips with an absolutely tragic expression on his face.

The circumstances of Laura and Patrick are so similar—both stoutly attempting superego control over expression of grief—that one is tempted to propose an hypothesis regarding the circumstances in which certain types of tic develop

While some of Laura's face fingering and clutching is probably connected with her attempts to control crying, her nose picking appears to be more of a masturbation equivalent. Unfortunately our written records do not give adequate attention to this behavior and we cannot be sure of the course of development. There is a possibility that nose picking, which is recorded frequently on the first four days and which is not recorded later, largely gave way to masturbation which definitely did not begin openly until the sixth day.

METHODS OF PSYCHOANALYTIC RESEARCH

It is our hope that this rather elementary discussion of the data—based on written records and a film—will do something to convince such skeptics as there may be that systematic observational records of this kind have an important place in psychoanalytic research.

All of us believe that a central feature in personality development is the organization within the personality of certain relationships to love objects. These relationships can be those of happy contentment with an actually satisfying mother, greed toward a potentially satisfying one, hatred toward a temporarily frustrating mother, a sour-grapes attitude toward a permanently frustrating one, and so on. Dependent on the balance and organization of these varying responses and the varying internal pictures of the love object will be the individual's actual responses to love objects in real life. He brings to his perception of these love objects certain expectancies based on the nature of his internal objects and in so doing commonly, first perceives the object as different from what it really is (either more or less satisfying) and, then, makes it behave so. In this way virtuous and vicious circles in love relationships quickly develop.

The traditional method of analytic study of these object relationships has of course been the study of the patient's behavior toward the analyst—the study of transference manifestations. This approach will obviously continue to be invaluable, but we believe that direct observation of the development of object relations in infants and young children will come to be recognized as an indispensable adjunct. The advantages of studying a person's capacity for object relations in the transference situation are well known. We are able to observe perceptual distortions as they occur and the consequent inappropriate behavioral responses. By means

of interpretation of the transference we give our patients the opportunity to compare their distorted perception with something nearer reality, and, by lifting repression, to enable them to discover the nature of their hopes and fears and how they came to have developed as they have. By these means we change our patients' internal worlds and, by changing them, come to understand them better.

Observational studies are different. Those which we are attempting concentrate on the infant's relation to the real love object, and seek to trace how the child's *internal* world of love objects develops as a result of the way in which he interprets his experiences of his *external* world of love objects. Naturally from birth itself his relationship with his love object is a function not only of his real experiences but of his internal expectancies. The more we know of each and the more we know of the way they interact the more we shall be able to understand human personality and its vicissitudes. Indeed, it is our belief that the key to our problems lies in our understanding of this interaction and that studies which give scant attention either to the internal world or to the external one will not carry us further. Our selection of the separation experience is determined scientifically by its being a grossly and unmistakably frustrating experience for the child and by our knowledge that it can profoundly and more or less permanently influence the state of the internal figures. This gives us the opportunity for studying the exact circumstances which lead to these changes in internal objects and internal organization during these critical phases of personality development, and of the nature of the processes concerned in their change. In Laura's case we have had the opportunity of observing the circumstances in which the processes of repression, projective identification and tic formation have been set in motion, and something of their course.

A major criticism which will of course be leveled at our study of Laura is that we had next to no knowledge of the state of her internal objects before the separation experience occurred, nor can we do more than guess at how this experience has changed them. This deficiency, however, can be made good next time. We hope in future to use analytic play and projective techniques to explore the child's internal world before, during and after the separation experience so that we have a more lively and exact understanding of her interpretation of the experience and of the internal changes which have followed it. In this way we hope to combine some of the advantages of the traditional methods of analytic exploration with these newer ones.

A particular merit of recording observations of the infant's and young child's responses to his real love object is that such observations can be made by more than one observer, they can be repeated, and when films

are made can be scrutinized by many workers. There is room also for all sorts of harmless little experiments similar to those which Rene Spitz (1946) carried out so successfully in his investigation of the smiling response. In this way it is to be hoped that there will develop among us a common body of agreed data regarding certain processes which occur in the embryological phases of personality development. We are fully aware that this will be neither quick nor easy. In the first place, as we have discovered over the past four years, the making of observations of this kind and their publication is extremely time consuming. In the second place, what one sees depends on what one is looking for and, on many finer issues, there will be differences of interpretation between observers. For instance, one of them will feel certain that such and such behavior is a clear sign of superego functioning while another is equally certain it is not. On such occasions we believe the useful step to take is for the two observers to thrash out together what it is in the observation about which they can agree, leaving aside for future consideration that about which they cannot. Many of the points about which they will be able to agree will be relatively hum drum, but perhaps as a Society we have had too little regard for the modest and hum-drum.

Our two great strengths in contributing to the understanding of personality and the illnesses from which it suffers have been, first, our willingness to make real human relations with our patients—in some measure to enter into their lives—and, secondly, our willingness to use our imaginations on what our observations mean, to theorize boldly. The academic psychologist has been weak in both these respects. But we have not been strong in the systematic matching of our hypotheses with systematically recorded and classified observations of relevant phenomena, until this is done, we believe, we shall be troubled by many intractable theoretical conflicts. Their resolution, we are convinced, will never come from our talking theory at one another. It will come from our gradual collection of relevant observations about the nature of which all can agree, and from the systematic discussion of their meaning. This film together with the written observations regarding Laura's behavior, have been recorded and are published in the hope that they will contribute to this slow accretion of useful if hum-drum observations.

APPENDIX

*Notes on the Film "A Two-Year Old Goes to Hospital"*²

This film was made while we were practicing combining written and cine records in the observational study of young children. Since these studies are concerned with the young child's relationships with love objects, the main purpose of both types of record was to obtain data on the child's responses to her mother and father and to substitute parent figures. Attention in the film is consequently concentrated on the child's responses when her mother and father are present or absent, how she treats the nurses, and how she behaves when alone.

Since the study was of behavior during separation from the mother it could have been made in any of a variety of settings but a hospital ward was chosen because, by taking a child from the waiting list it was possible to control the occasion and duration of the separation and thus to fit it into the limited and specific period which the workers had available. The condition of umbilical hernia was selected because it is one in which the child is healthy and in no discomfort before the operation, and the operation is so slight that the child patient is active and apparently free of discomfort a few hours after operation. It has to be remembered however, that in addition to separation the child experienced some strange and frightening events (e.g., rectal anesthetic operation, removal of stitches) and that for much of the time she suffered the frustration of being confined in her cot.

It was the purpose of the study to establish as high a degree of validity in the observations as is possible, to this end the following measures were taken:

(1) The research workers had no part in selecting the child, beyond specifying that she should have umbilical hernia and be within the age range eighteen months to two and one half years. The child was taken at random from the hospital waiting list by a clerk. She had been seen at the outpatient clinic six months previously and was not remembered. When it had been confirmed that she had not previously been separated from her parents, and that they would co-operate, she was accepted for study.

(2) A study of the child's family and of her history was made in the home before the separation took place. Film shots were taken of the child with her parents.

(3) During the separation experience, written records of her behavior and especially of her responses to people were made continuously throughout her waking hours, which on many days extended from 6 A.M. to 9 P.M.

²The research on the effects of separation is supported by the Central Middlesex Group Hospital Management Committee which is responsible under the National Health Service for the Tavistock Clinic, and by the International Children's Centre, Paris. Grants for filming have been received from a special fund administered by the Cassel Hospital and from the Trustees of Elmgrove.

(4) Before the child was admitted to the hospital the ward routine was studied, and a schedule of filming was drawn up in agreement with the Sister. Main events, such as the admission procedure and parental visits, were shot as they occurred and in documentary fashion, but most of the film recording was done on a time sample basis—that is, sequences were made of the same period each day and at regular intervals. What is recorded is thus determined by the clock and not by the predilections of the camera man.

(5) A minimum of interference was imposed on the ward. The child's cot was not isolated from the others. The ward was bright all day and required no artificial lighting. A hand camera was used. The result was that there was no apparatus to embarrass the staff, and in very considerable measure the ward routine was undisturbed.

(6) A limited follow-up was conducted to record responses on return home. The child paid little attention to the observers and, except on one or two occasions, took no interest in the hand camera. She was to some extent familiar with Mr. Robertson as a visitor to her home before separation, and during her stay in the ward appeared to regard him as a friendly and constant figure who in slight measure mitigated her experiences.

The main incidents depicted in the film are as follows:

Week Prior to Separation—Laura at home with parents playing in garden.

First Day of Separation—Admission, bath, put to bed. Sister's visit, surgeon's examination, morning time sampling.

Second Day—Morning time-sampling, rectal anesthetic, return from operation, parents' visit.

Third Day—Morning time sampling, Mother's visit in afternoon.

Fourth Day—Morning time sampling.

Fifth Day—Morning time-sampling, Mother's visit in afternoon.

Sixth Day—Morning time sampling.

Seventh Day—Morning time-sampling. Stitches removed. Mother and father visit in afternoon.

Eighth Day—Return home with mother.

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SEPARATION ANXIETY IN MOTHER AND CHILD¹

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INTRODUCTION

The following case presentation is a clinical contribution to the manifold problems of child psychology. It is an example of what can be done for a child under very limited circumstances. In many respects our report is incomplete. The child, a four year old boy, was not analyzed, but seen for about five months only, on the average of twice a week (twenty eight interviews in all). At the time of the treatment the data received from the mother were meager. Only some time afterward was she able to reveal and discuss some pertinent material.

Mrs. G. brought Michael to the agency only, because she wanted to place him in the day nursery so that she would be free to seek employment. Although she complained about his behavior vociferously on this occasion, she never considered that Michael might need treatment. Only when the agency staff refused admission to the nursery, because it was evident that the mother-child relationship was seriously disturbed, did Mrs. G. reluctantly agree to therapeutic interviews. She resentfully consented to this plan, because she was told this might make admission to the nursery possible, at a future date. Once this goal was reached, any further treatment was out of question. The mother showed very little co-

¹ The child was treated at the Greenwich Center for Child and Family Service, a family casework agency in Greenwich, Conn. As part of its service to Greenwich families, the Center operates a day nursery providing full day care for children from two to kindergarten age. All applications for nursery care are taken by members of the casework staff, and the decision as to whether or not to admit a child is based on the caseworkers' judgment of whether or not nursery placement will improve or damage the family relationships. During a child's stay in the nursery, the mother and/or father are seen regularly, sometimes each week, sometimes less often, by a caseworker.

Members of the casework staff are all graduates of schools of social work and most of them have had personal analyses. Each year a staff seminar conducted by an analyst is provided by the agency. In addition, a panel of psychoanalysts are consulted on individual cases. Consultation consists of periodic reviews of case material as it develops.

The agency is known in the community for its ability to help with problems of family relationships, but it is perhaps better known for the concrete services rendered, such as nursery care, foster home placement and so forth. Thus there is an opportunity to give psychological help to many people who would not ordinarily seek it.

accordance with mother's demand for cleanliness. To her this had been easily accomplished when he was one year old. His reactions in these early years had been unobserved as such by his mother who was absorbed in her own anxiety and nervousness.

Michael was free of illness until he was three. He then suffered a series of throat infections which precipitated a tonsillectomy. This was handled as an emergency, and nothing was said to him about this. His parents, distraught themselves over the idea of the operation, never thought of mentioning it to him because he was so little. Mrs. G. did not make this known to the caseworker until after Michael's treatment was over. Then she realized how serious it had been for him. She and the father had taken him to the hospital. She carried him in, undressed him, put him in a play pen while she ran to deliver a message to the father waiting outside. When she returned Michael was already on his way to the operating room. She stood helpless, listening to him screaming and crying as he was taken down the hall. The hospital rules did not allow her to remain. She was notified by telephone that he was all right. The following morning she and the father went for him. They found him in his bed woefully crying. His first words to them were: "You don't love me or you'd have come sooner." Michael never spoke of the tonsillectomy again, nor did his parents bring it up. He recovered rapidly and, once this was over, no further thought was given to the matter.

It was not until after Mrs. G. had witnessed Michael's sessions with the caseworker and had learned something herself as to the intensity of his fear about coming to the nursery, that the impact of this terrific shock suddenly dawned on her. She wondered if this had any bearing on his refusal to come. His first nursery experience had followed soon after the tonsillectomy. Therefore, in retrospect, there seemed to be little doubt about the answer to this question.

Although we did not have the benefit of this information during Michael's sessions with us, the fact that the mother mentioned it as she did, spontaneously and with interest, indicated some measure of her own gains from her child's treatment.

When the casework service of the agency was explained to Mrs. G. and the alternate plan of treatment for Michael was proposed as a preliminary step toward his admission to the nursery, she became more thoughtful about the child's difficulties. This was by no means easy for her and she regarded it at first as a rejection of herself. Her determination to achieve her own plans enabled her to consider treatment for Michael, and two months later she decided upon this. Her decision was not wholehearted; rather she was in despair because she could no longer cope with the child. He was getting more unruly, children would not play with him even when he bribed them with his toys. He was constantly in trouble. She was guided by the more placid attitude of her husband who did not have this trouble with Michael himself, and who encouraged her to try it.

In offering the treatment plan to the parents, the social and economic factors

in their situation, as well as the psychological needs of the family, were considered. Our ultimate goal was to help Michael accept the idea of coming to the nursery, but the underlying objective was to help the mother in her relationship with her child.

Since there are various references to the layout of the agency in the course of the paper, a brief description of the building follows: as you approach you see a large colonial style, mellow red brick building. At one side is the playground for the youngest group, filled with intriguing equipment being (usually) used contentedly by eight or ten children, thus the first view both child and parent receive, even before they enter the building, is of children enjoying themselves—an important part of the application process.

The basement and first floor of the building, with the exception of the reception room, are entirely devoted to the nursery so that, when waiting in the reception room, it is possible to hear various sounds of children's activities including laughter and crying.

The second floor is devoted to the casework staff of which each member has an office. It is on this floor that all interviews are conducted, with the exception of individual play interviews with children that take place in a special playroom on the third floor at the top of a long flight of stairs.

On the appointed day, Michael arrived with his mother who intended to leave him with me and return later. He had been all right on the way over, seemed willing enough to come, had promised his mother he would be good. As soon as he entered the building, however, he began to whimper and cry. When I met them in the reception room, he and his mother were pulling and tugging at one another. Michael was shrieking as his mother tried to get his coat off. She was reminding him of his promise, urged him to stay. Her voice was tense and shrill. The more she talked to him, the louder he hollered. I gave no attention to the scene but made a simple overture to the child, telling him it was all right to remain in the reception room, and that Mommy did not need to leave. He quieted somewhat but was still not too certain. After a while I suggested our going outside to Mommy's car (where I thought he might be more comfortable in familiar surroundings). He liked the idea and led the way. Mrs. G. told of Michael's mischief, how he had turned on the heater one very hot day and she thought the car was on fire. Meanwhile the child was restless, pulled at the cigarette lighter on the dashboard, and suddenly smoke poured out of the engine. Both of them shrieked in panic—a scene, more hectic than the first, took place. It was a simple matter to extricate the lighter, which Mrs. G. did after threatening Michael about the horror of his act.

When this subsided we went into the building. Michael completely subdued, clung to his mother who in turn clung to him. She interfered with every attempt I made to reach him, corrected him, chided him, told him just what to do.

The next two sessions, although not as dramatic, gave further proof of Michael's inability to leave his mother and of her unwillingness to give him up, even though this was what she wanted. At times he seemed willing to be friendly,

but his mother could not let him. His intense fear, and her anxiety, seemed to bind them closely together. I invited Mrs. G. to remain present during all of Michael's sessions with me, realizing that this was essential if we were to help him at all. Michael became more confident and his mother seemed more assured of my not intending to take over her child completely.

Immediately after this, Michael came willingly, arrived in good spirits and sometimes did not want to leave. While at times he showed some enjoyment in his play, was interested in each new toy object, he still could not sever himself from his mother. Nor could she content herself to let him be free from her. She was constantly fussing with him over something such as fixing his overall strap when it became loose, arguing with him about his choice of play, directing him how to play, warning him against breaking things or making too much noise. Once when he was playing with jackstraws, pounding on the play table to make them jump and laughing merrily over this fun, she warned him not to upset the table. He pounded all the harder. Instantly the table tipped and the jackstraws scattered all over the floor. She reacted with horror, scolded him harshly as he scrambled to the floor to retrieve them. He was getting his clothes dirty.

Michael made many demands upon his mother, wanting her to play with him, asking her opinion about this or that. When she complied he was never satisfied, when she refused he became angry. Playfully he made faces at her, teasing her to make faces back at him. She refused, chided him for such nonsense—it was not a nice thing to do. Another time he stacked dishes upon her head, ordering her to remain perfectly still so as to hold them. She obeyed without a murmur, sat stiffly and in obvious discomfort. I intervened saying quietly that Mommy was uncomfortable. He unloaded the dishes, turned to something else, and she relaxed perceptibly. Usually Michael got the best of his mother with his teasing and tormenting. She aroused his fears by weeping when he defied her openly. On one such occasion he jumped to her lap, hugged her tightly. She brushed him aside, complained that "he was breaking her neck."

Michael's aggression was never out of bounds. He loved to hammer and pound, to scatter things about, to make noise, quite in keeping with the ways of an active four-year-old boy. However, his mother's interference with any fun he was having served to frustrate him, and produced hostile aggression. Gradually, and only when I could be sure of not intruding upon the mother's province, I tried to change the emotional climate of these sessions. When Mrs. G.'s anxiety mounted, I told Michael his mother loved him, but was not feeling well at the moment. When he threw toys, or stamped on them, I hinted gently that he couldn't have them for play if he destroyed them. Michael showed no hostility toward me, and I found that he could respond to reasonable restrictions. I was never too permissive with him, but observed that a little compliance with his wishes satisfied his teasing.

The intense unhappiness of this mother's relationship with her only child was appalling. Her inability to detach herself from him for even a short time

was deterring to his treatment His fears were accentuated by her protection of him which was really dominance

When I had a chance to talk with Mrs G alone she apologized for her impatience but admitted that she could not stand Michael She criticized my handling of him resented my giving him a little toy dog because she was fearful lest his wanting things would become a habit Yet when I explained my reason for this she seemed to understand I pointed out that the success of Michael's treatment depended upon her co-operation with me during his sessions at least I felt too that she might find some relief herself from the trouble she had with him by observing my handling of him She showed interest in this and when assured that I was in no way finding fault with either her or Michael she agreed to remain in the background as much as possible

She revealed more information about herself which explained somewhat the cause of her distress Not only was she bothered about Michael but she was at odds with every member of her family She resented her father's having remarried soon after her mother's death many years previously She found it hard to forgive what she felt were injustices dealt her by members of her family She wore herself out trying to correct their so called accusations against her felt that everyone imposed upon her or took advantage of her She relied upon her husband to protect her against becoming too involved in these clashes and his more realistic attitude was a safeguard to her

Mrs G had been an only child for nine years before the birth of two sisters and a brother She had been a shy timid child afraid to meet people and had felt closely attached to both parents She never got over her mother's death (when she is eighteen) developed a tremor in one arm which still persists when she is under any strain She held strong convictions about family loyalty felt she had sacrificed herself for them and that recompense was due her rather than continued demands or abuses Mrs G responded to my sympathy for all she had suffered and confided to me that she did not want Michael to be like her and that she was misguided in looking for a perfect child

During the next six weeks Michael made considerable progress with only one or two relapses His mother did her best to remain in the background and except for an occasional order or correction she allowed Michael to play with me He became much more comfortable and spontaneous He loved to take things apart and put them back together Sometimes he took things home for Daddy to fix He engaged in imaginary play arranged parties planned trips always including mother and me He shared his ideas with me accepted mine was not dismayed by necessary restrictions He turned to Mommy frequently for reassurance or approval but his demands upon her modified Mrs G was less tense herself and even though she did not always approve of my indulgence of Michael she waited until he was not present to complain On these occasions I explained to her about the emotional development of children the essential importance of their early years and of how sensitive they were to the happenings around them She was interested in this and in her own way began to see how this pertained to Michael I interpreted some of this behavior as being

appropriate for his years, whereas his clinging to her belonged to a child much younger. She understood this in connection with Michael's reaction when his two-year-old cousin visited in his home. Impulsively, Mrs. G. had agreed to take care of this child during his mother's illness, then regretted her generosity and complained about the relatives for having asked her. I wondered why she undertook so much when she was not feeling well herself. She was relieved to hear me say this, she knew she was not feeling well, but no one except me believed it. She was able to make some concession in favor of Michael in this instance by modifying her agreement to part-time care of the younger child.

There were three dramatic incidents of real significance in Michael's treatment. After he began to show more confidence in me and was willing to leave his mother for a few brief visits to the playroom with me, I proposed a session without his mother present. He seemed intrigued with the idea and we made our plans in advance with Michael very much a part of this. On the appointed day when I met him at the door and his mother went off shopping, he was overwhelmed with terror the minute he stepped into the building. Although his mother and I had prepared him for her leaving, we had obviously underestimated the depth of his fear. Had I known about the early trauma of his hospitalization when he was left suddenly to an unknown and painful happening, this would have been handled differently. As it was, I thought only of his reacting to his mother's departure. Although he had been very friendly toward me, he turned against me with vehemence and declared his feelings in a wild display of temper. My words of assurance meant nothing to him—and rightfully so—because I did not know the roots of his fear. The tempestuous scene that had occurred on the day of his first session was re-enacted in some measure. When his mother returned and found him still at the doorway yelling and screaming, she too reverted to her earlier reactions, scolded him fiercely for treating her thus. She had done her part, why couldn't he do his?

Michael's confidence was shaken but quickly restored in subsequent sessions when he was sure Mommy was here.

The next relapse occurred when I took him for a visit to the nursery playroom. This was not suddenly planned, but only after several successful sessions spent away from his mother. In his own enigmatic way, Michael one day consented to go to the kitchen (across the hall from my office) to wash the doll house curtains. From then on he moved into the kitchen and did not mind being away from his mother. He became intrigued by water play, household tasks, shared many confidences with me, telling me about his playmates, his little cousin, what they did to him. He did things his Mommy would not allow such as splashing water, climbing on cupboards and telling stories. He ran to his mother occasionally, but for the most part was absorbed in his play and did not care if she waited or not. From the kitchen window he could see the children playing in the nursery playground. He was curious and interested, wanted to be with them. So we went for a visit.

There was absolutely nothing on the surface to warn me against the sudden change that overcame Michael. He skipped down the hall beside me, chatted

gaily about having fun, yet as soon as we neared the threshold he stopped still, clung to me, a spasm of terror gripped him. He could not move an inch. Again his mother was disappointed, but this time she did not scold him. The child was trembling when he returned to her.

Michael could not tell me the reason for his fear—he did not know himself. He showed no ill effects of this experience once it was over. Later on he visited the nursery with his mother when the children were not there. This time he was all right. Spontaneously he chose the playroom for our sessions and allowed his mother to wait downstairs in my office. Gradually he was able to be away from her without having to check every few minutes to be sure she was there. In these sessions he had me read to him, sat on my lap sometimes, or stood close beside me. He played with the doll house, imitated his mother at her household duties, talked about her, told how he liked ‘to annoy her’ because ‘she annoys me’. He would not annoy me because ‘I like you’. Sometimes he really did annoy her by making faces at her or scattering things about. After the sessions her rebukes were milder, but her patience was sorely tried.

In discussion with me she complained of Michael’s vacillating, thought he was deliberately tormenting her by refusing to go to the nursery. She had put off going to work for a long while, had given in a lot to Michael, so felt that he owed her some consideration. I could understand her feelings about this delay, commended her for the effort she had made, and explained that Michael did not see things our way. It was for us to be patient.

Meanwhile, Michael was very comfortable with me, showed affection for me, confided to me his hostile and loving feelings toward his mother. He talked about the nursery and showed a desire to be there with the children. It occurred to me that he was sharing his ‘secret’ with me. I whispered to him that I knew he would not go to the nursery where he could have fun because his mother wanted him to go. He darted to the doll house, busied himself cleaning it up, scolded me because things were not in place. He ran downstairs to his mother, capriciously played hide and seek with me. The next day he was friendly upon arriving, but soon he became aggressive and provocative. He broke up the picture puzzles, scattered the pieces all over, seemed determined to destroy things opposed to me in every way. Without warning he dashed downstairs to his mother and hid behind her chair. As though struck by some force beyond her control Mrs. G. launched into a tirade against Michael. He was making a fool of her—she didn’t care if he were her own flesh and blood—she would make his life as miserable as he was making hers. She burst into tears, arose from her chair as though to leave. Michael, stunned by the suddenness of his mother’s anger, crouched into a corner, sobbed loudly.

Momentarily the intensity of this emotional display astounded me. When I regained my composure I explained to the mother that Michael could not help acting as he did; that she and I had pressed him too much about the nursery. He was still frightened and we must wait until he is more certain. I realized her disappointment and how trying this was for her.

Michael’s recovery from this ordeal was phenomenal. Mrs. G. telephoned to

check on his next appointment. She was sorry for what had happened. He had been very good ever since, was asking to come back. She wondered if I would ever want to see either of them again? I assured her of my welcome, implored her not even to mention the word nursery to the child.

On the day of the next session and without further ado, Michael ventured into the building by himself. When he met me he announced that he was alone. He wanted to go to the nursery and play with the children.

Our next three sessions were spent in the nursery. Each time his mother was waiting to greet him when the time was up. The following week he came full time, visiting each day according to the usual procedure. He managed these new experiences very well, slept through the first nap period, awakened in a bappy, carefree mood.

Michael remained in the nursery for six months before entering kindergarten. It was a happy and profitable experience for him. He showed initiative and imagination, captivated the children by his ingenious ways. He was not always willing to share his ideas with them, was at times quarrelsome and aggressive, but he was not afraid.

Mrs. G. continued her visits with me while Michael was in the nursery. She went to work soon after and felt better to be back in the business world again. Her social life expanded and her anxiety about family matters modified. Consequently her attitude toward Michael changed. She talked about the things he did, which were not so different from before, but they bothered her less. She was able to handle him more constructively and sometimes his teasing amused her. He told her that he knew she loved him because he had come to the nursery. This made her realize that he must have been afraid she did not love him when she was trying to force him into the nursery. In looking back on happenings of the past, Mrs. G. spoke of Michael's tonsillectomy when he was three years old. She wondered if this had anything to do with his refusal to come to the nursery.

In a follow-up visit with Mrs. G. two years later she responded with real interest in my inquiry about Michael. She revealed that family life is much more harmonious and that she is getting a great deal of satisfaction out of it. Laughing good humoredly she said that Michael was, at times, a little devil, getting into all sorts of mischief. With pride and pleasure she told of his accomplishments with his music lessons and in school. I was impressed by her spontaneity and interest in this discussion, and by her cordial welcome of my visit. The former tension and anxiety which had suggested a more serious disturbance was no longer evident in the same proportion.

It is my impression that she looked upon Michael's treatment as an education for herself. Her parting comment to me was that I had taught her to be a social worker.

COMMENTS AND CONCLUSIONS (*Else Pappenheim, M D*)

Without doubt the reader will be aware of the tremendous difficulties the caseworker was faced with in treating Michael. It required a great deal of skill, tact and sympathy to accept this mother with all her open hostility and her constant interference and not to side with the appealing, attractive little boy. It was of utmost importance to show the mother that her problems also were taken seriously and that the worker was not only interested in the child. She had to make it clear to Mrs. G. that her only desire was to help both of them in their troubled relationship so that Mrs. G. would be able to enjoy her child more and at the same time gain the freedom she so much desired. At the same time the worker had to convince the mother that she had no intention of estranging Michael from his mother. This was particularly difficult since we had the strong impression that Mrs. G. hardly looked upon Michael as a child in the sense of his being a separate individual. He was the object of her exclusive possessiveness—an object, however, that was highly cathected narcissistically. She wanted to get rid of him yet at the same time letting go of him seemed extremely threatening. Her reaction to some of Michael's behavior, for instance, his scattering the jackstraws all over the place gave one the impression that she felt as though she were falling apart herself. Her display of tremendous anxiety about separating from Michael was part of the same picture. It literally seemed to mean that a part of her self was being torn away from her. She apparently was repeating here in some way her relationship to her own mother. She stated that Michael clung to her, the way she had clung to her mother, and that she never really got over her mother's death although she was eighteen at the time. Another source of Mrs. G.'s reaction to separating from Michael must have been her strong guilt feelings with regard to him. However, we had no inkling about this, until some time after the treatment.

It is interesting that Michael's presenting symptom, his inability to separate from his mother, was manifest only in relation to the plan of nursery placement. Otherwise, apparently, he would stay with relatives without any difficulties and let his mother go. He understood very clearly that his mother's purpose was to be free to pursue her interests in a career. She said this much very openly in his presence. But he must also have understood that she unconsciously preferred a job to him, therefore, this specific situation became so threatening. With his symptom he not only forced his mother to stay with him but he also retaliated by preventing her from doing what she wanted to do most. He also must have been aware of his mother's fear of breaking to pieces. In his aggressive moods he would break things and throw them around. As soon as he

calmed down, however, he would try to fix them or suggest to take them home for his father to repair. One of his favorite occupations was putting picture puzzles together. If he did not succeed, he would ask the worker for help. This plea, however, could also be used in an aggressive way. Then he would throw pieces around, would not let the worker retrieve them, and so on. These activities seem to point to a variety of factors. They probably were related to his own castration fears (the pleasure most children of this age derive from making picture puzzles and similar things may have the same meaning) things that are broken or taken apart, can be put together again. Even if one cannot do this oneself, some friendly adult will help (wanting to bring broken objects home to his father, even bringing his father's tools to the office, or turning to the worker for help). They furthermore must have been related to his mother's fear in this respect, since his destructive breaking of things was always provoked by her and directed against her. I would think that he feared castration from her, not from his father. This seems to be borne out by his whole relationship with her which was of a preoedipal nature: clinging, demanding, possessive. All his libidinal and aggressive drives were vested in his mother, whereas his relationship to his father seemed to be one of trust, admiration and affection. The father did not seem to be a rival and, therefore, no threat. At that time, at least, there did not seem to exist any passive submissiveness toward his father, but a healthy identification with him as evidenced by his playing the general or the captain. The father's attitude, too, must have been important. He did not complain of any difficulties in dealing with Michael. He showed real concern for and interest in him, and mentioned with obvious pleasure how Michael would follow him around happily when he was repairing things around the house.

It was clear that the mother-child relationship was very disturbed, at least at this particular phase in their lives. Yet there had been difficulties from the time Michael was born. Mrs. G. allegedly wanted a child very much, mainly because she hoped this would make her life easier, but she was married for five years until she conceived. She was disappointed from the beginning, because he was "a fretful, restless baby" and she was "amazed" at the difficulties in bringing up a child. We may safely assume that she was really disappointed because he was a boy. She never admitted this, but she wanted a "docile, submissive" child and preferred his playing with girls. She believed that one should let an infant cry, for fear of spoiling him. When speaking about this, she only complained about the annoyances his crying had caused her, but she did not seem to have felt any compassion with the child. On the contrary, she resented and criticized her mother-in-law and her husband for picking up the child to

comfort him. We do not know in what way toilet training was carried out, except that it was accomplished "very easily" by the end of the first year. Knowing about Mrs. G.'s fanatic cleanliness, we can imagine the rest. We also have no information about masturbation, yet we witnessed innumerable veiled castration threats: He would burn up with the car, break her neck, vivid descriptions of war and wounded soldiers, etc.

The only way in which Michael could get a response from his mother was by aggressive behavior. She did not react to his pleas for help, be it as a crying infant, or in his anxiety about separating from her. (The most important example of this kind, a tonsillectomy and its obvious implications, will be discussed later.) She did not respond to his tender approaches. When he tried to embrace her, she sat rigidly on her chair and only complained: "You are breaking my neck" and "He loves me too much." However, when Michael became aggressive, she did react. She yelled at him, threatened him, pulled him around. She actually behaved exactly like the child, even on a more infantile level. It seemed that she invariably provoked him into aggressive behavior. She apparently could not bear it, if Michael was engrossed in some playful activity. He may have been building something or chatting away happily, when Mrs. G. would interfere, tell him what to do and how to do it, warn him not to break things, or correct his fantasy play: "You ought to know better, a truck cannot talk." Once when he described how he would take his mother and a girl friend along on a trip in the future, she behaved as though this were happening right then and there and remonstrated. Without his mother's provocation his play seemed to be normal. He also responded easily to any restrictions imposed by the worker.

Mrs. G., of course, behaved in the same manner away from the office. She objected to his playmates because of bad language, she was afraid he might break his toys, etc. She particularly forbade him to play with any child with whom he had had a fight. It was only after the treatment had ended that she could tolerate this. She expressed her amazement to the worker that children could be friends again so soon after they had been enemies only a short while before.

Michael showed two forms of aggressiveness toward his mother: an all-out destructive behavior and a more teasing one. His destructiveness was always provoked by his mother: by her scolding, threatening, and interference with his activities. His teasing manner came into play when she paid no attention to him. Then he would interrupt her reading, trying to get her to join his play. He would hurl commands at her with which she complied with masochistic submission. She would sit motionless while he piled toys on top of her head, but bear the expression of a martyr on her face. (This behavior was, of course, characteristic of her;

she constantly managed to be taken advantage of by her relatives and then resented this bitterly)

One hardly can speak of a neurosis in this child, only of a symptom apparent in relation to his mother. In every other respect he seemed well. His vocabulary was better than average, his manual skill and motor development excellent and his imagination vivid. Later when he had entered the nursery, the other children often accepted him as a leader, because his ideas were so good. (He complained about this to the nursery school teacher "Make them stop stealing my ideas, I thought them up.") He was generally happy and cheerful. He responded easily and well to people. His relationship with his father and other relatives was good. He became immediately part of the nursery group and was from the beginning not treated like a 'new child' by the others. He also related easily to the worker, even though he insisted on his mother's presence.

What was it that saved this child from a severe neurosis? Was it the father who accepted mother and child? Did the father's very acceptance of the mother, of whose problems he was aware, give the child enough security, telling him she really was not so dangerous? Or was the relationship with the mother more positive than it seemed to be at the moment? We considered Michael's persistent struggle for his mother's affection as a sign of health. But would he not have given up this struggle, if his experiences with her had always been negative? Was Mrs. G. always so rejecting and so disturbed? According to her own information, her marriage was satisfactory, she was always successful and well liked in her business relations. Her real trouble seemed to have started with Michael's birth. Having a child was very different from what she had expected. Rather than a relief, it was a burden. And this burden seemed to grow with the increasing demand of a growing child. She was faced with many real difficulties at the time she came to the agency. The family had moved to a new community and bought a new home. This was a serious financial strain for the G's and provided a rationalization for Mrs. G's seeking employment, something she had wanted all along. Michael was the only obstacle to her fulfillment of this wish. However, she apparently took it in her stride when nursery placement a year earlier failed. It seems important that then Mrs. G. was dissatisfied and removed Michael from the nursery, whereas now, the agency and the child refused to submit to her desires.

Let us return to the treatment and review what happened there. There were two important turning points: first, Michael's ability to stay alone with the worker, and second, his decision to come to the nursery. The first event took place when he was told that his mother, too, came to see the worker without him to discuss her problems with her. This ap-

parently meant to him that his mother would not resent his staying with the worker, she would not consider him disloyal and punish him with desertion because he had left her. Since he understood so well his mother's unconscious wish to abandon him, he must have feared that his leaving her would be understood by the mother likewise. He probably also felt guilty about his hostile impulses toward his mother and only her presence could assure him that he had not killed her. We know that internalized aggression, i.e., guilt, can cause separation anxiety. But, if his mother turned to the caseworker for help, the worker really must be a powerful person who could protect him against his bad impulses and thereby alleviate his guilt. (The worker had proven her power over Mrs. G. in other respects, by telling her she would take responsibility for Michael's behavior in her office.) We do not know exactly why the water play was so important, except that it was an activity which his mother did not permit him to indulge in—he was apprehensive about getting his clothing wet at first—yet one in which she herself indulged a great deal. He did say, scrubbing away enthusiastically: Mommy always does this. Maybe he was satisfied to be allowed to identify himself with his mother. One of his favorite games in the nursery was playing house where he would take the father's as well as the mother's role in fulfilling various household chores. Maybe on a deeper level it meant that he was permitted to masturbate, mother (the worker) did not object. However, since we do not know how his masturbation was handled, we cannot make such an interpretation with certainty.

In an offhand remark Michael gave us a great deal of insight into the mechanism of his aggressive behavior directed against his mother. As an answer to the worker's question why he persisted in running to his mother all the time, he replied: Because she annoys me. If we take Michael's reply literally, it must mean that he was seeking his mother's presence, because of her aggressive, possessive (annoying) attitude. Mrs. G.'s behavior, motivated by her own anal sadistic character structure, caused a fixation of Michael's libidinal development on the same level. Their mutual love was of a preoedipal nature. In the same session Michael made another, equally revealing remark. When the worker asked him, why he did not annoy her instead of his mother, he replied: 'Because I like you.'

The second turning point Michael's voluntary entrance into the nursery seemed like a paradoxical reaction to a misinterpretation. The worker told Michael she had discovered a 'secret' about him, namely that he really wanted to go to the nursery and only refused to do so because his mother wanted this to happen. Michael's response to the interpretation was turning away from the worker angrily and running to his

mother The next day he was openly aggressive toward the worker and "annoyed" her, like his mother The interview ended with one of the worst scenes between mother and son The "secret" was obviously not that he wanted to come to the nursery, but that he loved the worker and hated his mother But only two days later, Michael spontaneously expressed his wish to go to the nursery We do not know what happened Did the worker's admission that they both, she and his mother, had made a mistake in urging him so much mean that she also admitted her mistake with regard to the 'secret'? Or did he fear he would lose both their love through his obstinate refusal? We have to admit that we do not understand how this came about, but when Michael arrived the next day, he was full of happy anticipation, eager to join the other children

With Michael's entrance into the nursery, the treatment was ended However, the mother came regularly to see the worker It was at one of those interviews that Mrs G revealed an extremely important piece of information showing a great deal of guilt about it Mrs G remarked to the worker, she was sure that his great anxiety about leaving her was connected with a tonsillectomy which he had to undergo at the age of three Michael stayed alone in the hospital for twenty four hours When his parents came for him the next day, he was besides himself and told them, they did not love him, or they would have come sooner The mother did not say more about this incident at the time Two years later, when the worker made a home visit and asked Mrs G more about it, she was able to give all the details, as described in the case report This hospital experience really seems to give the clue to Michael's as well as to Mrs G's intense reaction to the impending separation The parents did not prepare the child in any way for the operation consciously, because they thought he was too little to understand, unconsciously, because it must have been a castration threat to them Maybe the mother also had unconscious death wishes against the child At any rate she seemed to be in an acute panic herself and ran away from the child, to get her husband When she came back, the child was in the process of being dragged to the operating room, without a chance of saying good bye to her and apparently without any sedation To the child this must have amounted to an experience of complete abandonment, possibly even annihilation The mother felt completely helpless, panicky and guilt ridden In contrast to the indifference which she had displayed earlier, when she spoke of his crying as an infant, she described the hospital experience with real compassion She truly had suffered with and for her child Yet her rigid character structure made it impossible for her to show any of these feelings to the child She even tried to place him in a nursery shortly after ward The parents never mentioned the hospital experience to Michael

The boy himself never made any overt or hidden references to it during his play sessions. It seemed to be a completely repressed trauma. Yet the words *nursery* and *nurses*, and the fact that there were children in both places, must have evoked his overwhelming fear. This would account for his panic when the worker tried to bring him to the nursery for the first time. It probably was a repetition of what he felt when he was taken to the operating room without his mother. Again his mother was not at his side at a crucial moment. Again she did not love him and we know that she really preferred a job to being with him. Only after we had this information did we understand why mother and child could not separate from each other. To both of them it must have meant abandonment and possibly death.

Without doubt the treatment, short lived as it was, has done a great deal for mother and child. Michael goes to elementary school now, is well liked and a good student. Mrs. G. is better able to accept her son and even to enjoy him. Of course her main desire, to have a job, is fulfilled and she is very satisfied with it. This also means that she does not spend very much time with Michael. After he comes home from school, he is being taken care of by a neighbor, until Mrs. G. returns from work. Whatever the reason, she does not appear as sick now as she did at the time when she contacted the agency.

Having Mrs. G. accompany Michael to the nursery for an extended visiting period, might, in the opinion of some, have achieved the same result. This procedure was not followed because in my opinion the treatment prevented the outbreak of a full fledged neurosis. Michael's symptom, his fierce resistance to parting with his mother, at a moment when he was requested to become a member of a social group was probably a neurosis in *statu nascendi*. To force him to attend the nursery would have been a repetition of the serious trauma of the year before. I consider the relationship to the worker the decisive factor in bringing about the amazing result of the treatment. This relationship, though of short duration, was of equal importance to the mother and to the child. The caseworker's warmth and patience were so contagious that even as rigid a person as Mrs. G. had to react to them. She could make scenes and still she was permitted to return. She could admit her intolerance of Michael and be met with understanding rather than with blame. She had an opportunity to observe how somebody with whom she was not as involved as with her husband or her mother-in-law could handle Michael's behavior skillfully. She learned to some extent, through identification with the worker, to be less provocative. ('You taught me to be a social worker'. This in itself would have lessened the child's need to be so aggressive toward his mother. Beyond this, one might speculate that the

caseworker, as a tolerant and loving mother, has merged to some degree with his real mother and made the latter less threatening. I doubt that the worker's repeated reassurances that his mother loved him had any influence. But he must have known that the worker loved him. This in itself may have helped Michael to become more detached from his mother. The treatment enabled Michael to gain comparative freedom from his mother and to become a member of a social group. This may very well have paved the way for him toward a more healthy emotional development. The mother became able to let go of her child, maybe to look upon him as a separate individual rather than a part of herself. I believe this was a result of her identification with the worker and not of real insight. I am inclined to ascribe Mrs. G's improvement to the job rather than to the treatment. It is a job of exacting nature which must satisfy many of her compulsive needs. It furthermore gives the family greater financial security, thereby providing a legitimate excuse. Most important of all, the job permits Mrs. G to be away from house and child for most of the day. In my opinion Mrs. G would appear as sick as before, were she forced to give up her job and assume the exclusive role of mother and housewife again.

SUMMARY

We consider this case important because it suggests a number of questions and considerations.

(1) The constant interaction of aggression and counteraggression of hostility and yet inability to let go of each other, finally the development of a common symptom show clearly the communication between the mother's and the child's unconscious. At the same time, in spite of their strong influence upon each other and their intense preoedipal relationship we can by no means speak of a complete mother-child union. Otherwise it cannot be understood how this child of a severely disturbed mother had remained comparatively healthy. The only explanation seems to lie in the fact that in spite of the prolonged dependence of the human child on his mother, the latter is partly only environment and therefore her influence is limited by the child's constitutional endowment. Of course only a great number of observations of a psychological and biological nature can throw any light upon the question of constitutional factors.

(2) This case is a drastic example of how hospitalization in children should not be handled. Unfortunately, every physician, many parents and social workers can enumerate similar cases. Not only did nobody think of advising the parents of the necessity of preparing the child (it is

doubtful of course that the G's could have followed any such advice), the hospital routine of taking a child unexpectedly and without sedation to the operating room, and the rules, enforcing a twenty four hour separation of mother and child, seem unbelievably inhuman

(3) The asymptomatic repression of the severe trauma is another question we cannot answer Michael's clinging and possessiveness, about which Mrs G complained so much, do not seem necessarily pathological in a three to four year old who was not permitted to play with other children or even his own toys That the symptom did manifest itself at a time when a repetition of the traumatic situation occurred, does not seem to need further explanation

(4) Even under difficult circumstances—limited number of interviews and lack of information about the most important event in the little boy's life—excellent results can be achieved This was largely due to the child's relative health but equally, if not more so, due to the caseworker's skill and sympathy

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ANIMAL PHOBIAS IN A TWO-YEAR-OLD CHILD¹

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CASE PRESENTATION

Linda was referred for treatment at the age of twenty three months because of attacks of paroxysmal tachycardia for which no organic or any other cause could be found. The first attack occurred when she was seven months old. These attacks began with animal like grunts which were different from any other cry. They occurred usually during the night and lasted for several hours. She often would be feverish during the attack and fall asleep toward the morning. During the attack she would assume a crouched position and fall asleep on her knees and elbows. Before an attack she would often complain of a bellyache. At nine months of age the attacks became more frequent (two or three times a week) whereupon the family doctor and the cardiologist advised hospitalization for the purpose of observation. Her pulse rate during these attacks was so rapid that it could not be counted. Although the child was very upset in the hospital she did not have any attack there during her two week stay. Because of the attacks a tonsillectomy was recommended and performed at the age of nineteen months. However it did not affect the severity of the attacks nor the total behavior of the child. It rather increased the frequency of the attacks which occurred now every few days. She was hospitalized again at twenty one months this time in a different hospital where she remained for three weeks. Again she had no attacks during her stay in the hospital. The consulting psychiatrist advised analysis for the child and psychiatric guidance for the parents.

The mother reported that toilet training had started very early at the age of six months and that Linda had been completely toilet trained at nine months. After her second hospitalization Linda had regressed and both wet and soiled herself occasionally especially before and during an attack. She often screamed when the mother attempted to change her wet clothes and at times she refused to go to the toilet. The mother reported that Linda had become cranky and irritable and was clinging to her. In addition Linda exhibited another peculiar symptom. For no apparent reason Linda would become cranky and withdraw with her blanket into the corner of her crib or of her room. She would sit there in a crouched position as though she had cramps constantly fingering her blanket, licking her tongue and grunting. She would remain like this for hours apparently removed from reality. Later on during the course of Linda's treat-

¹ Read in part at the Panel on Symptom Formation at the Midwinter Meeting of the American Psychoanalytic Association December 8 1951

ment when the mother had become more observant and had more insight into Linda's behavior, the mother could always detect a connection between this withdrawal and some frustration which Linda had experienced

The mother could not understand why Linda was so timid and inhibited because she considered herself to be an unrestrained person and a progressive parent. Both parents were in the habit of walking around in the nude before the child mornings and evenings. The mother was astonished when I suggested to her to acquire and to wear proper night attire (Neither she nor her husband possessed any nightwear). There was no toilet privacy and Linda had had sufficient opportunity to observe her parents in all their toilet functions. There was no doubt that the child had overheard and probably observed parental intercourse from a very early age on.

The onset of Linda's attacks seemed to coincide with toilet training and weaning from the bottle. Both occurred quite abruptly around the age of seven months. After the tonsillectomy Linda started wetting during the day especially after an attack. This day wetting was a particular source of annoyance to the mother. On the other hand Linda also seemed to show some compulsive traits: she was much concerned with cleanliness, picked up scraps of paper from the floor and always arranged things neatly and orderly.

When Linda started therapy she was twenty three months old and her mother was in her seventh month of pregnancy. Linda was a physically well-developed child with an unusually well-developed language ability which greatly facilitated her analysis. She appeared to be very docile and eager to please. She always was spotlessly clean and very careful not to dirty herself. She also was very cautious in handling the toy material and never broke or tore any of the toys. Neither in her behavior nor in her play did she give any indication that she remembered her tonsillectomy or the hospitalizations. The only overt reaction to the tonsillectomy according to the mother, had been a reluctance of Linda to take food which required chewing.

The birth of the brother occurred during the summer vacation (Linda was then twenty six months old) and the mother reported that Linda had shown no overt reaction to this event. However shortly after his birth she developed a severe anorexia and an acute sleep disturbance. She would wake up nightly and scream in fear: "a doggy is biting my finger" "a kitty is biting my finger" or "a fish is biting my finger". It was almost impossible to calm her: she was up most of the night. I shall give the mother's report of one such night: Linda was carrying on from twelve midnight right through until 7:00 A.M. [According to the mother's description she seemed neither fully asleep nor fully awake. It appeared as if she were acting out her nightmare.] She kept screaming out in her sleep: "the fish are eating my fingers" "the cats and dogs are biting me". She didn't know where she was: she kept on saying "I want to go home". She didn't know me and when I attempted to pick her up she screamed and almost jumped out of her bed. I kept on reassuring her that there were no animals in her room or in her crib or on her face. She seemed to be wiping off the fish from her face."

Linda carried over these probias of fish, dogs and cats into the daytime. Once her mother brought a fish home Linda screamed in terror. She was afraid

to go out into the street for fear that she might see a dog or cat. In the analysis, a feeding game with dolls revealed how she dealt with oral sadistic impulses. She was at first very fearful of feeding the doll, withdrawing her finger as soon as she came close to the doll's mouth. She was afraid that the doll would bite her finger and swallow it. The interpretation of the projection of her oral sadistic impulses, namely, that she was the one who would want to bite and swallow something of which she was afraid, brought to the fore her jealousy of her baby brother. After this interpretation she began to speak about him and also became interested in anal play. The birth of the brother apparently had not only reactivated but also dangerously intensified her oral sadistic impulses which had suffered a severe inhibition under the trauma of the tonsillectomy.

When her oral sadistic impulses had been worked through Linda's fears gradually subsided, she began to talk of her and her brother's genitals referring to them as "toushies." Another factor which seemed to contribute greatly to Linda's oral conflict was her penis envy. This also was brought out in her play with the dolls. While she maintained that everybody had the same "toushies," she made the very correct distinction between the boy and the girl doll in the way in which she had them urinate, although both dolls had no genitalia and the difference in their sexes was indicated only in the way they were dressed and by the face and the hair. When I made a boy of clay with a penis she took the penis off but otherwise treated the clay doll as a boy. From her play with the dolls, it was obvious that she knew of the anatomical difference yet was denying the existence of a penis. This behavior was particularly surprising since she had had all the opportunity to observe her father's genitals who had taken her with him to the toilet when he was urinating. It would seem that Linda had been and still was unable to tolerate consciously any idea of castration. The intensity of her penis envy, which she had completely repressed and which showed itself in her fear of having her finger bitten off, could be understood on the basis of the penis being cathected with oral libido. The fact that the baby was a boy had reactively intensified the impact of the earlier deprivations—weaning, training, tonsillectomy—which all were "losses" inflicted upon her by her mother. The denial of the existence of the penis and the displacement of the affect from it to her fingers meant that she still possessed all these lost objects—nipple, stools, penis, fingers—which she now feared would be taken away from her by oral sadistic attacks. This was a projection of her own oral sadistic impulses, and at the same time a way in which the objects she desired, particularly the penis, were protected from her oral sadistic impulses.

The release and working through of these wishes and impulses brought on a very remarkable improvement of her sleep disturbance and anorexia. Occasionally she would still cry out at night and call her mother whom she wanted to pet her and to reassure her. On such occasions she would sometimes say, "I don't like the pussy," or "Make the doggie go away," but would go back to sleep promptly. Sometimes she would wake up crying and say, "Don't go away Mommy, I want to go with you," but she could be soothed by her mother and fall asleep again.

This waking up at night was different from her "attacks," which had been

the original cause for her referral for treatment. These attacks still occurred, though less frequently and for shorter periods. It was very surprising both to the mother and me that as soon as Linda had started her play sessions her attacks had diminished in frequency and intensity. After her first visit with me she did not have an attack for two weeks, while prior to that she had had two to three attacks a week. After half a year of treatment she had stopped wetting herself except immediately before the attacks. The mother now referred to these attacks as "disturbances." This indicated a significant change in the mother's attitude, namely, her acceptance of the emotional origin of her child's condition. The mother also told me that now she could get Linda to stop grunting during the attack. For instance, one night when Linda had awakened her and she was grunting and obviously starting a "disturbance," the mother asked her to stop grunting and to let her sleep. Linda said, "Alright Mommy, go to sleep. I won't grunt any more." She actually stopped, but still called her mother several times before she fell asleep. Sometimes Linda would talk about her play with me when she awoke during the night saying that she was feeding my doll and enumerating all the food items she was giving her. This seemed to reassure her and put her to sleep and to prevent the onset of an attack. It seems that in doing so Linda was establishing a relationship with me which served to counteract her rising anxiety. The sources for this anxiety seem to lie in the early oral and anal deprivation, reinforced by the experience of the primal scene. It is noteworthy that of all the games which we played during the analysis, the feeding game retained its (symbolic) significance throughout most of the treatment.

All during this time I had not seen the child in such an attack except once, shortly after she had started treatment with me. The mother told me that Linda had been cranky that morning and had started to grunt. She showed all the signs of a developing attack. When I saw her she looked very unhappy, was whining and appeared to be fearful. She felt warm to the touch and had a very rapid pulse. When she saw me she brightened up and readily left her mother to come with me for her play session. The session apparently aborted the attack. I had the definite impression that Linda's attack was an equivalent of an acute anxiety attack in which the affect of anxiety was missing (though not completely), while all the physiological accompaniments of anxiety were exaggeratedly present. I learned from the mother in the course of Linda's treatment that Linda was able to shake off an attack on the days when she was told that she was coming to see me. This would seem to support my diagnosis of anxiety attacks and also indicate that Linda was experiencing relief of anxiety in her relationship with me. A further corroboration of this assumption and an impressive proof of the immediate therapeutic effect of the play sessions was furnished by an episode which occurred when Linda was about three years old.

According to the mother, Linda had been in very good spirits that morning and as usual was looking forward to her play session. When she and her mother were ready to leave, friends of the mother called. They offered to take them by car to my office so that they could spend the time together while Linda had her play session. Linda suddenly became very disturbed. She refused to leave, saying that she would go by train. She began to whine and complained about a

bellyache She was very upset when her mother picked her up and put her into the car During the ride to my office, Linda had worked herself up to an attack of paroxysmal tachycardia of such severity as the mother had not observed before The mother could not understand what had happened Nothing she did or said could comfort Linda Linda looked pitiful She was doubled up on her mother's lap, yet not clinging to her mother but rather appeared to be pulling away from her She appeared to be terrified and in a panic She looked as if she were in a daze and she did not recognize me but continued to whimper when I talked to her I kept saying to her again and again, 'This is Mimie [the name by which my very young patients call me], Linda' After some time she seemed to come out of her daze and let me pick her up from her mother's lap and carry her to the playroom

For the past few sessions we had been playing with paper dolls The books, dolls, and plastic scissors were lying on the floor. Instead of taking them up as usual, she sat listlessly and avoided touching them She seemed particularly afraid of the scissors which she had handled quite skillfully before I started to cut out a dress As I picked up one of the paper dolls to put the dress on it, a piece fell off Linda was very frightened I began to tear the doll up saying, 'Nothing happens, we can even cut it up, nothing happens It is only a paper doll' Her face lit up and she became more lively and accepted my suggestion to try to cut up the doll herself After a while she took the scissors and at first fearfully, but then in a more determined way, began to cut the doll up This was the first time that she had allowed herself a frank display of aggression in the play session While cutting she became quite excited, saying with glee, 'Cut up dolly, Linda cut up dolly' In the meantime her behavior had completely changed When the session was over she walked out by herself very much to the surprise of her mother who did not know what had started nor what had ended Linda's attack. While I had some ideas with regard to the latter, it took me a long time until I was able to find out some facts which helped me to understand what had caused Linda's severe anxiety that day

Linda became more aggressive in her play sessions now, however, without ever becoming destructive She began to play with other children and even ventured out on her own onto the street She became altogether more independent of her mother She was going to nursery school and proved to be a very capable and bright child Her anxiety attacks or "disturbances," as her mother called them, occurred very infrequently and had lost their original character They now resembled the phobic clinging of older children in whom the association of phobic behavior with somatic symptoms, especially with stomach aches is a rather frequent finding These attacks manifested themselves by Linda's becoming moody at such times, complaining about a bellyache and clinging to her mother

One day Linda spontaneously brought up the subject of the tonsillectomy She told me that her friend had undergone a tonsillectomy and then said, "My tonsils have been cut out too" The mother also told me that Linda had spoken about the tonsillectomy to her and that she had mentioned some details which made it obvious to the mother that Linda remembered the actual event. Linda

remembered that she had been taken to the hospital by car and that there had been other people who had come with them. The mother confirmed that Linda had been taken for the tonsillectomy by the same friends who had brought her to my office on the day when she had the severe, acute attack of panic. In the light of this information Linda's behavior that day, and particularly her pulling away from her mother, became more intelligible. Linda had displaced the repressed memory of the traumatic event to the car and to the friends of her mother. The circumstances on the day when they called for her had revived this repressed memory and as a result produced the panicky state.

Although Linda was doing very well now, I continued to see her because the enuresis had recurred at the age of three and one-half years.² Thus, I could follow up her development during the oedipal phase. It was remarkable how well Linda passed through this difficult phase. Between four and one-half and five she liked to play with figures which she herself made of clay. She would usually make a family consisting of the mother, father, the older child, a girl, and the little child, a boy, each with all the appropriate sexual attributes. One day she made a girl and said, "She is going to get married." Then she made a boy with a penis and said, "They are going to make a baby." Whenever Linda played family, she announced, "I'll be the big sister." That day when leaving she told her mother, "I'll be a mommy myself and have a baby." Linda is now eight years old and has continued to develop and to function adequately in every respect.

DISCUSSION

Forty-five years ago Freud (1909) developed some of the classical concepts of the phobias from the analysis of five-year-old Hans. Since then the technique of child analysis (and particularly that of play analysis) has enabled child analysts to study directly neurotic manifestations in children of preoedipal age. Berta Bornstein (1934) in "Phobia in a Two and One-Half-Year-Old Child" found that a latent instinctual conflict which dated from the time of training, and which was reinforced by traumatic circumstances led to the phobia of this child. M. Wulff (1927) described a similar observation in a child of one and one-half years of age. In this child the phobic behavior started at the time of toilet training and could be resolved through counseling of the parents. E. Hirschmann (1915, 1937), H. Deutsch (1929), and others emphasized the role of the aggressive impulses in the phobias.

I reported the case of Linda because it presented me with an opportunity to observe the formation and resolution of her phobias during the treatment process. Her case also seemed of interest for the study of the sources of anxiety and for that of symptom formation in a young child. Linda suffered from attacks of paroxysmal tachycardia. This

² The treatment of the enuresis proper will be reported elsewhere.

diagnosis had been made originally by the family physician and the consulting cardiologist and was confirmed later on the occasion of the two (diagnostic) hospitalizations. In her analysis these attacks were found to be equivalents of severe anxiety (attacks). These attacks started at the time, when the coinciding experiences of weaning, toilet training and primal scene observation forced an abrupt repression of oral and anal impulses. The grunting and the position which Linda assumed during the attack and later on when she was able to talk, her complaints about bellyaches definitely pointed to the fact that she had conceived of intercourse as an anal act. M. Klein (1932) particularly has emphasized the traumatic effect of the observation of the parent's union in intercourse upon the young child and his reaction of rage to it. Linda's paroxysmal tachycardia would indicate a state of intense excitement, probably resulting from a mixture of fear, frustration and rage. The inhibition of the biting and chewing functions following the tonsillectomy would indicate that Linda had interpreted the operation as a punishment for her oral sadistic impulses. It may be of interest to mention that Linda's brother when he was only two years old had become a terror to Linda and to the children in the neighborhood because he would bite them so fiercely that he would draw blood. Linda's father suffered from a duodenal ulcer since adolescence and an unusually severe inhibition of aggression. After the tonsillectomy Linda was clinging to her mother while at the same time the periods of withdrawal with the blanket which obviously served to substitute for her mother became more frequent. This would indicate a further repression of aggressive impulses and of hostility toward her mother with the subsequent fear of loss of object relationship. In fact, during the periods of withdrawal Linda behaved as if she had lost her mother already. Early in Linda's treatment I found it necessary to suggest to the mother that she occupy herself with Linda constantly at such times when she was withdrawing and not to allow her, as the mother had in the past, to remain withdrawn for hours. Even though the mother complained that this was a very difficult task for her because Linda was very cranky and rejected her mother at such times, it proved to be an effective means of improving the relationship between Linda and her mother. The birth of the brother in this precarious situation was a trauma of such magnitude to Linda that it threatened to shatter completely her already very labile relationship with her mother. The birth of the brother seemed to confirm to Linda that her mother did not love her, that she had replaced her with the baby, whom she not only allowed all the pleasures which she had taken away from Linda but to whom, in addition she had given something which she had denied to Linda, namely, the penis. These feelings had some justification in reality, because Linda's

mother could not conceal her delight over having produced a boy child. She was a basically sincere and honest person and while feeling badly about it, she could not deny to herself that she had rejected Linda from birth on because of her sex. She had identified her with her own mother, grandmother and sister, all of whom she considered to be inferior and for whom she had little use. To be a female meant, for Linda's mother, to be weak, helpless and dependent. Her grandmother, mother and sister had not had any boys and had always depended upon a man and upon her for support in every way. Linda reminded her particularly of her grandmother whom she had always hated. She could see where Linda was growing up to be just like this grandmother, whining, cranky and a nuisance to everyone.

Linda's severe anorexia following the birth of the brother could be understood as a depressive equivalent resulting from the repression of oral sadistic impulses. Because the penis was cathected with oral libido, it became of vital importance to possess it—in accordance with the unconscious equation of penis breast mother. Much which otherwise would have had to be attributed to constitution could in Linda's case be found to be the result of earlier experiences. Because of our knowledge of the history preceding the onset of the acute phobias, Linda's predisposition to react to the birth of the brother in this particular way could be understood to be an acquired rather than an inherited constitutional quality.

In the face of this desperate situation, the denial of the existence of the desired objects and of the dangerous impulses proved to be insufficient. Linda was confronted with both an intolerable internal and an equally intolerable external reality. In this situation—the danger of the imminent break through of the repressed impulses from within and the loss of object relationship with the mother and all its consequences that is, depression or psychosis—the formation of the phobias proved to be a saving device. Similarly as the organism defends itself against the invasion of highly toxic agents, for instance in septicemia by localizing the process and externalizing it by the formation of abscesses, so in the phobias of Linda, the general invasion and complete disintegration of the psyche was prevented by localizing and externalizing the destructive energies of the pregenital impulses by means of projection, condensation and displacement.

1 By the mechanism of projection an intolerable inner danger stemming mainly from her own oral sadistic impulses was transformed into an outer danger, namely, the fear of the biting animals. In this way she managed to escape from the otherwise inescapable danger in the waking state by (the mechanism of) avoidance and in the sleeping state by awakening.

2 By the mechanism of displacement the fear of the mother, who in Linda's unconscious figured as the castrator having deprived her of oral and anal pleasures and in addition having replaced her with the baby brother whom she gave a *penis*, was displaced onto the dog, cat and fish. Linda had used the mechanism of displacement in other similar situations. She had displaced the traumatic and repressed memory of the tonsillectomy in which the mother figured as the castrator onto the car and her mother's friends. Linda was very much afraid of noises or more specifically, she had a fear of the noise of the vacuum cleaner which could throw her into a panic. In analyzing Linda's reluctance to go to the bathroom it was found that she was actually terrified by the noise of the flushing of the toilet. Neither she nor her mother had been aware of this fear which she had at least partly displaced to the noise of the vacuum cleaner. From the noise of the vacuum cleaner she could escape by (the mechanism of) avoidance, by staying in her room and locking the door or running next door to the neighbors when the maid was using the vacuum cleaner. To be consciously so terrified of the toilet would have made her life even more painful. The vacuum cleaner lent itself particularly well to substitute for the toilet because of the fears she had, namely, the fear of the noise and the fear of being sucked in and to disappear in the toilet—vacuum cleaner.

3 By the mechanism of condensation all these impulses, wishes and fears primarily directed toward her mother and brother were condensed in her phobias in accordance with the unconscious identification of nipple breast mother stool penis finger.

The analogy between the phobias and the dreams, which Lewin (1951) pointed out in his paper "Phobic Symptom Formation and Dream Interpretation," would seem to me to hold true not only with regard to their structure but also with regard to their function. According to Freud (1900), the function of the dream is to insure sleep by allowing the repressed impulses and wishes to emerge, in a disguised form, in the dream. Projection is one of the most important mechanisms used in the formation of the dream. Why is it necessary to project these repressed impulses and why may the dreamer not (even in the sleeping state) experience these impulses and wishes as coming from within but only as dangers coming from the outside. Lewin (1951) states that the disturbing elements in the dream, "the wakers," are always projected outward because they originally came from the outside and were represented by the threatening father. Linda's case and numerous cases of phobias and phobic sleep disturbances in children which I have analyzed do not seem to confirm this statement. My experience in Linda's case would rather indicate that "the wakers" come from the child's own aggressive—

pregenital—impulses which are directed toward the mother, the original object to satisfy or to frustrate these needs of the child

The dangerous impulses which are dealt with by projection in the anxiety dreams as well as in the phobias are pregenital impulses. The danger comes from the increase in the destructive impulses when the balance between libido and aggression is shifted in favor of the latter, and is perceived by the child as intolerable anxiety. By the mechanism of projection, this danger from within is transformed into a danger in the outside, from which the dreamer can rescue himself (often only at the last moment) by anxious awakening. During the time when Linda suffered most from her phobias and nightmares the mother was the only one who could comfort her, at least to some extent. Only later when her relationship with her mother was improved through the analysis could she accept also her father and others and did not insist upon the presence of her mother. Such behavior is commonly found in children who suffer from phobias and/or nightmares. Such children usually want the mother to comfort them and to take them to bed with her. The fact that the mother is present and comforting the child is reassuring and serves as a denial of the existence and effect of the dangerous, destructive impulses. In addition, the putting on of the light, looking around and recognizing that it was only a dream and that there is no immediate real danger serves to support the denial of the internal danger.

It seems to me that the real danger which is thus warded off is the danger of permanent loss of reality which would result from the sudden breakthrough of the destructive impulses (self or object-directed) into consciousness. Dreaming is a state of loss of reality, however, this loss is limited to the sleeping state and is reversible. In the case of Linda, the structure of her nightmares and of her day phobias was identical and served the same purpose, namely, to prevent the break in object relations and with reality. By means of her phobias Linda managed to limit the loss of reality to the phobically feared objects proper while she could maintain the essential functions and relationships, particularly the most important relationship with her mother. The phobias in Linda's case as one might put it served to get her through the dangers of the Scylla and Charybdis of a depression on the one, or (paranoid) psychosis on the other hand.

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EMOTIONAL IMPLICATIONS OF TONSILLECTOMY AND ADENOIDECTOMY ON CHILDREN¹

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AIMS

The psychological significance of surgical procedures in childhood is now generally recognized (Coleman, 1950, Deutsch, 1942, Fries, 1946, Jessner and Kaplan, 1949, Levy, 1945, Lindemann, 1941, Menninger, 1934, Michaels, 1943, Miller, 1951, Pearson, 1941, Pillsbury, 1951). Helene Deutsch (1942) found evidence in the analysis of adult patients that "operations performed in childhood leave indelible traces on the psychic life of the individual." David Levy (1945) and Pearson (1941) found in psychotherapy with children that operations experienced earlier in childhood had a traumatic effect on some patients. In our work with children we were impressed that in some cases the onset of emotional difficulties was attributed to an earlier operation.

Our knowledge of the meaning of operations in childhood comes mainly from retrospective studies. We felt that direct observations of children undergoing surgery would contribute to the understanding of this problem. While we plan to study a number of operations, we began with a most common operation in childhood, tonsillectomy and adenoidectomy (T&A). We were not only interested in the effects of operation, but also wanted to find out how children experienced short time hospitalization and minor operation.

PROCEDURE

From November, 1947, to February, 1952, 143 children were observed while they were undergoing T&A at the Massachusetts Eye and Ear Infirmary. These children were unselected except for their accessibility for follow up. This depended upon their living sufficiently close to the hospital and upon their mothers' willingness to co-operate with the study.

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² From the Psychiatric Service for Children, Massachusetts General Hospital and The Massachusetts Eye and Ear Infirmary, Boston, Massachusetts.

It is the practice at the Infirmary to admit the child for a period of two days, one preceding and one following operation. The child was first seen by a child psychiatrist at the time of admission.³ The mother was interviewed by a psychiatric social worker who attempted to get specific information regarding the child's development, previous experiences of stress (illness, operation, hospitalization, life experience), and preparation for the operation.

Each child was observed at intervals during the hospital stay by the child psychiatrist. In addition, nurses who had been informed of the aims of the study made notations of the child's reactions on the ward. Sixty-two children were given psychological tests.⁴

When possible mother and child were seen in follow-up interviews—within a week or two, at the end of a month, and at longer irregular intervals. At present we have three to four year follow-ups on nearly forty children.

LIMITING FEATURES OF THE PRESENT STUDY

Although our study was designed to secure detailed information on each of our patients, we were not always so successful. The greatest gaps in our information appear in the follow-up material. Many of the mothers who expressed interest in the study when it was discussed prior to the child's admission for T&A, lost much of their enthusiasm once the acute phase had passed and were reluctant to return for additional interviews. When the health of the child improved, mothers were apt to regard a discussion of the postoperative reaction as anticlimactic. With other mothers, where no such improvement occurred, there sometimes was resentment toward the hospital. This seemed particularly true for those mothers whose expectations were colored by magical thinking, as exemplified by the mother who had expected her child's feeble-mindedness to be cured. Several families moved away from the Boston area and were lost for further follow-ups.

Even had we not encountered these difficulties, we would still consider our information as incomplete. Except for the few psychotherapeutic cases, our observations are neither extensive nor intensive enough to grasp the full significance of the operation for each child. While in some cases the child's emotional reactions appeared with dramatic vividness, in many we could not properly evaluate the extent to which suppression

³ Five children were seen two or three times prior to admission, and two had their operation during psychotherapy.

⁴ Of these thirty-three were given a selective battery including projective tests for the purpose of predicting the child's reactions. These results are reported elsewhere (Rubin 1951).

and denial may have clouded the picture. We obviously could not determine the extent to which reactivation of the experience in later years might occur.

It should be emphasized that our findings may not be representative of T&A's in general because of the special conditions that prevailed at the Massachusetts Eye and Ear Infirmary. Before we appeared on the scene the Social Service Department, recognizing the importance of preparation for the child, had issued a booklet for parents helping them to explain the operation to the child. Nurses, anesthetists, and doctors were all cognizant of the child's emotional predicament and tried to minimize the threat to him as much as possible. It was for this reason that hospitalization one day prior to T&A was instituted. It was hoped that this would give the child some time to become acclimated to the hospital and thus reduce his anxiety.⁵

Also we found that the psychiatrist could not remain a neutral observer, but was drawn into a friendly relationship with the child. While this was helpful in obtaining more meaningful material, it modified the hospital atmosphere. The psychiatrist was frequently perceived as a friendly, supportive figure, as was born out by the spontaneous remarks of many children, both at home and in follow-up interviews.

OBSERVATIONS

Preparation

It is generally felt that preparation for a painful and frightening event reduces its traumatic impact. The parents in our study were urged to prepare their children fully and were given a printed booklet by the hospital to assist them. Nevertheless, it was found that in a number of cases preparation was either misleading or grossly inadequate because of the parents' own anxiety about the operation or ambivalence toward the child. In several instances the effect of such preparation was seen directly in the child's reactions.

For instance *Joseph*, age seven, together with his brother *Stephen*, age four, was tricked into coming to the hospital by their overprotective mother. She had informed them that they were going to buy a pair of shoes. In the hospital *Joseph* was restless and when blood was taken he struggled so that it needed four nurses to hold him. He threatened to have them arrested. He would not admit his fears but projected them on his brother *Stephen*. He mentioned how ever that he expected to be hurt and had fantasies of being injured. Immediately after the operation he appeared warm and relaxed but was "scrapping."

⁵ Evidence that a friendly supportive atmosphere reduces the severity of a child's reaction to hospitalization is presented by Huschka and Ogden (1938), Jackson (1942), Pillsbury (1951), and Prugh et al. (1952).

his throat and twisting his neck. His four year-old brother displayed only general anxiety and cried during hospitalization and at follow up visits

It seemed not accidental that Joseph who was completely misled reacted in a panicky and almost paranoid way, with no recognition of the helpful aspects in the hospital, experiencing every manipulation as malicious torture

Rose,⁶ a bright girl of four had not been told by her highly ambivalent mother either that she would be operated upon or that she would stay overnight in the hospital. Before the operation she was very quiet and restrained and said that her mother was somewhere in the hospital. The next morning she denied having slept at the hospital and insisted she had been at home. After the operation she seemed depressed without tears and maintained that she had slept in her own house. She denied ever having seen the psychiatrist before. One week after the operation she seemed to cling more to her mother than ever before. She would not talk about the hospital except for saying that the nurses were mad. She would not recognize the psychiatrist and denied that she had her doll with her in the hospital. Three months after the operation she appeared less tense, and while she still would not talk about the hospital experience she admitted that she had had a T&A, asked if her brother would have his tonsils out and played out the operation on a hospital set. After seven months she did not play the hospital game any more, but talked about the T&A. After eleven months she liked to see the play doctor and play hospital.

Our impression was that the child's denial of reality was to a large extent due to the lack of preparation.

There was quite a range of explanations given to lure the children to the hospital. One boy was told that he was to be fitted with a new pair of tonsils, another that he was going to a new school. A third was told that it would be 'like going to a hotel'. Two brothers were told they were going to buy some soap. One mother told her four year old daughter they would visit the hospital and that she could stay if she liked it.

There were several instances where preparation seemed overdone. This was strikingly illustrated by the mother who started preparation six weeks prior to the operation. She played out each detail of the hospital procedure, going so far as to lay the child on the kitchen table and place an ammonia soaked rag over her face in order to simulate anesthesia.

Most of the mothers seemed able to prepare their children fairly adequately for the operation. We realize that preparation involves more than simply imparting information to the child. The parents' own feelings can color the presentation of the facts so that the child's apprehensiveness might be heightened rather than diminished. While intellectual preparedness helps maintain a proper reality orientation, it is inner preparedness—i.e., the extent to which the child has been able to master his anxiety and marshal his defenses to cope with the impending danger.

⁶ Mentioned in preliminary report (Jesner and Kaplan, 1949)

—that affects the final outcome. The manner in which this inner preparedness is achieved varies from one child to the next, with some maintaining their own misconceptions and fantasies about the operation, despite their having received accurate information.

The following case is one in which preparation was done with the view of putting the child into a state of preparedness by allowing him to work through his anxieties and mobilize his defenses.

William, age four years, two months

*Preoperative preparation
by psychiatrist*

Fear of being kept in
the hospital

Castration fear

Selfreassurance that one can
come out all right and the wish
that the operation were over

Castration fear—hospital
as place to fix up

Fear of enclosure and too open
a space

Considerable anxiety
preoperatively

In the first interview ten days prior to T&A the psychiatrist encourages the patient to play with him with a toy hospital, while talking about a boy who will have his tonsils out. The patient remarks there are no doors. How do you get out? There ought to be more windows don't you think so? The patient asks if the windows were broken and remarks about broken things. What happened to them? Psychiatrist gives the reassurance that toys break other things don't.

The patient picks out a boy figure saying He had his tonsils out he had them out two days ago.

He inquires about exact operative procedures and is given information.

In the second interview he plays with a farmhouse and animals. He wonders about a horse with a broken leg which he tosses to the hospital to be fixed. He wonders why there are no doors to close in the farmhouse. He says it is too open. There ought to be more room on the edges for the animals to walk around.

At home according to mother, he held his penis a lot and wet himself in the daytime three or four times. He ate hardly anything except oranges.

On admission

Armor of familiar things and strengthening himself with his possessions

Identifies the hospital with a jungle and himself with a survivor who acquires food

Fluctuates to the other extreme by identifying hospital with hotel

Vacillates between identification with baby and with father—self-reassurance that shaving (cutting) does no harm, and pain as stimulating pleasure

Evening of the first day

Emphasis on being grown-up

Reassurance against castration fear

*In operating room—
waiting*

Postoperative

He brings with him a great number of toys. He speaks of Little Black Sambo who gives his clothes away to the tiger, goes into the jungle, which seems to refer to his anticipation of the operation.

The patient constructs a house out of domino pieces with a walk around it, saying there are many rooms and how you can have fun in a hotel.

He frequently uses baby powder, but more often an after-shave lotion, two items he has brought along. Daddy has some, but much stronger. It stings. That feels good.

He insists that mother sleeps in crib and that he sleeps in the big bed, but later accepts crib for himself.

He speaks about the table being made of wood that won't break; plastic can break. He tests the table and is relieved that it is made of wood. He remarks that sometimes wood breaks but iron bends.

He is quiet and subdued. He asks questions about doctor's mask, etc., and holds on to lollipops, plays with toy animals. He co-operates with the anesthetist, but under anesthesia struggles—"No, stop it, don't."

He asked whether his tonsils were really out. While in the hospital he was anxious to see whether he could eat a whole meal

Expectation of change which would make him capable of unlimited intake

and whether he could swallow better. He cried when it was denied him. He wanted more ice cream than allowed for. During the night he wanted mother to call the family doctor because he felt awfully sick. The next morning he was playing cheerfully, reluctant to leave the hospital. The parents had the impression he couldn't believe it was all over.

Possessions as fortifying

At home he wanted all his toys and books around him, not to play with, just to be around him.

Identification with aggressor and acting out castration

He pretends to pull off father's nose and fingers. He tries to cut the leg off a flower stand. He plays cutting his own finger and wants a band-aid.

Fluctuates between the devourer and the devoured

On the following day he ate a great deal and wanted to know from what animal meat came. Pointing to his chest, he said: "If it's here, they must cut off his face."

Reassures himself by differentiating between essential and superfluous parts of the body

He plays with a doctor set and a doll as patient, using the headband and stethoscope, like his doctor. He gave penicillin shots in the buttocks. He took a toy dog's eye out and put it in again, remarking that real dogs could get their eyes sore. He asked his mother: "But they stay on, don't they?" Mother confirmed it and the patient said, "Not like tonsils." He told mother when he heard he had to have his tonsils out he was so scared his head almost fell off. He was most frightened after he knew it and before Dr. B. told him about it.

Abreaction by repetition

A week after T&A he dressed up in a doll blanket and quilt, pretending it was a hospital johnny. He declared his window to be the hospital window and that he was going down to play in the hospital nursery. This continued for a few days

and when he had the visit of a friend he played doctor with him, mainly examining his throat and injecting penicillin

According to his mother, the patient did not wet himself since the operation except one night after he got a splinter in his finger. He did not hold his penis after operation, ate very well and seemed relaxed and happy at home and in follow up visits (two and four weeks postoperatively) without talking about the hospital

The Hospital Experience

One of the major sources of anxiety for the child in coming to the hospital is separation from those he loves (Edelston, 1943, Huschka and Ogden, 1938, Jackson, 1942, Prugh et al., 1952, Senn, 1945). In our patients we found that separation could have different meanings. For some children, separation was experienced mainly as *loneliness*.

After her mother left Joanne, age two and a half, said 'It's dark in the hospital. She cried softly and was quite sorrowful. She climbed up the cribside and put her arms around the psychiatrist, and whenever he returned she reached out for him.

Not all the children could accept a parent substitute as readily as Joanne. A few spent most of the time lying in a fetal position and gave the appearance of a child in grief. Others were able to obtain some relief by observing that there were other children in distress. For some, separation was so painful that they denied they had been in the hospital overnight, and a few insisted that their mothers had slept in another room.

Some children adjusted rather cheerfully following the mother's departure, but in moments of threat they showed a desperate need for her *protection*.

Frank, age three and one half, reacted strongly whenever he saw something done to other children—for instance, a child receiving an injection. He repeatedly asked the psychiatrist in panic: 'What did they do to her?' The answers did not reassure him and he would persistently ask for his mother at such moments.

Carol, age five, was able to handle the anxiety of not having a protector by assuming the protector role herself. She wanted her mother whenever needles appeared, but was able to decrease her anxiety by adopting a little colored girl

who came to the ward. She insisted on mothering this girl although the other child seemed quite self-sufficient.

Several children expressed the fear that their parents would not return. For them separation apparently represented complete *abandonment*. Others indicated in their behavior that they regarded the hospital as a kind of *jail*.

Frequently, being in the hospital presented the child with problems in maintaining his *identity*. The pastel-flowered rompers of the hospital were especially threatening to the masculinity of some of the boys. Being in a crib was upsetting to many of the older children because it meant returning them to the inferior status of the younger child. Some children, who had acquired techniques of mastery for familiar situations, were at a loss as to how to behave in the strange surroundings of the hospital.

Defenses against loss of identity and feelings of unfamiliarity were manifested in a variety of ways. One girl remained at home with her thoughts. She talked almost exclusively about the furniture and what the family was doing at home. Others compensated for their loss of status by bravado and boasting.

The hospital for some children may represent the place where one gets babies.[†]

Roberta, age five, was hospitalized with her brother Robert, age four. One year earlier their mother had given birth to twins. Both children spoke about Robert's bank with six dollars to buy babies. Roberta reported that she had discussed it with her grandmother who said they should get black babies so that she wouldn't have to wash babies so often. After the operation she began to eat enormously and four years later was quite plump. She seemed to use food as comfort, probably to make up for the loss of the tonsils and the frustration of her hope for babies.

Conceptions of Tonsils and Adenoids

For many children tonsils and adenoids had considerable symbolic significance. Such conceptions were frequently fostered by the mother's own tendency to regard the tonsils as the focal point of the child's difficulties. For instance, the mother of a fourteen-year-old schizoid girl hoped the T&A would correct everything that was wrong with her. Two mothers of feeble-minded children expected the T&A to make them brighter. The mother of a severely disturbed boy attributed the change in his disposition at age two and one-half to his bad tonsils. Several expected enuresis to disappear. Others hoped for cure of infantile eczema and of asthma.

[†] Beta Rank, in her discussion of Edith Jackson's paper (1942), stressed this point and illustrated it with an example.

For many children the tonsils were the place where the "bad stuff" The tonsils were often conceived as demons or dangerous enemies. Thus, one ten year-old girl thought that if the tonsils "meet in the center you die"

For children with obsessional trends "bad" had a definite moral connotation. T&A was anticipated as an exorcism where the bad will be cut out, torn out with pliers, burned out or melted away with ether. Helene Deutsch (1942) calls attention to the fact that the obsessional neurotic will use organic disease for the purpose of loading and unloading feelings of guilt.

Arthur, age seven like his father, suffered from psychogenic headaches. He stated that his bad behavior was responsible for his father's headaches. He was sure that his own headaches were caused by his fight with his father and his headaches made his adenoids grow. Preoperatively he expressed guilt feelings because he had not confessed his sins. Postoperatively his headaches improved.

While most children know that the tonsils were in the throat, for some they were "something deep inside the body". This conception was often maintained side by side with a correct knowledge of their location. Even postoperatively some children located their tonsils in other parts of the body despite having experienced pain in the throat. Most thought it was in the "belly" which for each child had a special meaning.

Donna, age five stated three months postoperatively that the tonsils had been in her belly. They cut the belly open to take them out. This was connected with her fantasies of getting a baby.

Barbara, age six pointed to her chest as the site of her tonsils and stated they will squeeze blood out of it. This notion seemed related to her conception of the illness of her father who died of tuberculosis.

For some children the tonsils represented another organ, e.g., testicles, eyes, or teeth.

Lucy, age six thought her doctor would poke her eyes out. She was offered tonsils in a jar but refused to take them because they were gushy pushy. She continued to talk about her doctor's eye mirror.

David, age ten was very interested in the anatomy of the tonsils and described the pictures of tonsils he had seen in *Life* magazine. Nevertheless two weeks postoperatively he insisted that his tonsils had not been taken out and that he could see them pointing to his uvula. In the context of this boy's strong fear of mutilation and castration the uvula represented the penis.

Some children regarded the tonsils as analagous to teeth. They expressed a desire to be paid for the tonsils just as for their teeth and were resentful when no payment was forthcoming. Some expected a second set of tonsils to appear, like teeth.

Removal of the tonsils seemed for some children a threat to the intactness of the body. For some children the tonsils severed from the body and to be seen as objects seemed gruesome. One boy called them "a piece of meat." The operation turned flesh into meat and evoked cannibalistic fantasies. A few children began wondering about animals and where and how the meat was gotten from them. A number of children did not want to eat meat for a while after the operation and we guessed that early devouring fantasies motivated such refusal. Also, other edibles were occasionally renounced. Paul postoperatively would not eat Queen Anne cherries and finally said they looked like his tonsils. Particularly the children with obsessional trends expressed resentment and narcissistic hurt at the thought that the tonsils would be thrown into the garbage pail.

The Meaning of Narcosis

One of the aspects of the operation that loomed large in the expectations of the children—mainly the older ones—was the narcosis. The children invariably called it ether, a word with an aura of mystery.

For a good many children narcosis represented the threat of death. Helene Deutsch (1942) has pointed out that "the fear of death mobilized by the expectation of an operation is connected first of all with narcosis anxiety." While this expectation was common enough, some of the children indicated the fear of death before operation, others expressed postoperatively the feeling of having been suffocated or smothered.

Carol*, age six, whose younger sibling died six months earlier, expressed her fear of death openly before operation. She brought a doll dressed as a nun with her. Her play consisted mainly in restoring things to their previous state. Her postoperative reaction was a relief that she didn't die.

For some children the anesthesia had the character of punishment or execution, and a frequently used defense mechanism against this fear was to be either very good or rebellious. For other children narcosis meant a murderous or sexual attack.

Stanley, age eight, whose mother had been very anxious since an older brother died when the patient was two years old, had not slept the night before admission and worried how he would sleep in the hospital. He thought he would get "knock-out drops" and asked at another time if they would "knock me out with

* Mentioned in preliminary report (Jessner and Kaplan, 1947).

a hammer." The anxiety was so great that he tore off the mask on the operating table.

Russell, age thirteen, whose father and uncle had died of tuberculosis, described postoperatively how he had seen ether used in the movies: "You count one, two, three." In coming out of the anesthesia he screamed and ran wildly around the ward. The following day he said he had not liked the ether. He said he felt funny coming out of it, but would not talk about it.

At follow-up six weeks later he said the worst thing was the ether—three or four whiffs made him feel funny. He said when half awake coming out of it he felt scared: "I saw two men coming for me with knives and guns. I could see their faces, but they were no one I knew. I was scared. I jumped up and tried to run away. That's when I awoke and the nurse took me back to bed. I was very scared. I thought they were trying to kill me."

In connection with this memory he stated that one of his forms of entertainment was rolling down hill, which made him feel dizzy but good.

He had derived a mixture of fear and pleasure from anesthesia. Such a *masochistic element* was not uncommon among the reactions to anesthesia.

Walter, age five, also was mainly concerned about anesthesia. He had had a previous T&A one year ago, which was followed by enuresis. Seven months after the present T&A he remembered that he didn't like the ether; it smelled awful. He didn't dream under ether but now he dreams there is a whole gang of people coming to kill him, and they tie him up, throw him in the river, and he wakes up screaming, "No, no, no." Then his mother comes in when he does this. He continued by telling that during the T&A he wondered whether his mother left him because she didn't want him.

Death, meaning *separation from mother*, is expressed in the ether dreams of *Angela*, age eleven. She related a dream that she had during anesthesia. There was a cliff off to the side, and she was on the cliff. There was a voice crying, "Mommy, Mommy, Mommy." It was the same dream she had during narcosis for a mastoid operation seven months ago.

The fear of *loss of control* during anesthesia seemed to be the chief concern of the older children. Sometimes it was the fear of losing control over one's own impulses and at other times the fear of losing control over the environment.

Peter, age twelve, had the experience under anesthesia of things going round and round. Finally he let go when things were black. He thought he would go crazy. He wanted to fight back, but "then they went away."

On the other hand, with some children the thought of getting ether was *reassuring*. They derived comfort from the fact that they would not feel anything. The fear was rather that they might be awake during the

operation For some it seemed that pain was terrifying and they wanted to avoid it by all means For others the submissive tendencies were gratified by having something done to them while they were unconscious

The Meaning of the Operation

For many of the children the operation had the meaning of mutilation or castration

Six months prior to T&A the Children's Medical Service had referred Michael, age four and one half for psychotherapy when he asked if the pediatrician was the doctor who was going to cut his penis off For two years his mother had threatened him with castration because of his enuresis

Michael was prepared in psychotherapy one month prior to operation After preparation he dreamed he undressed a nurse In psychiatric interviews he drowned a nurse exhibited his penis and the day before admission punched his therapist in the genitals He expressed his desire to kill his father and the fear that his father would kill him He was concerned that a plasticene figure had no penis demanded that one would be made and placed it

On admission for T&A Michael was controlled and solemn while his mother was with him When she left he sent a kiss for his sister but staunchly refused to send one to father Following mother's departure Michael cried for several hours but with frequent visits of his psychiatrist he regained control He mentioned he won't let himself dream because he dreams bad things He wet at 6 P M but was dry all night The next morning he was serene talked freely about the impending T&A but later on showed more anxiety While waiting for anesthesia he copied the activities of other children

The morning after operation he could hardly wait for mother to come and dissolved in tears when she arrived Two weeks later he seemed subdued and refused to talk about the operation He didn't know what was done to him and reported a nightmare of being killed by a bear Three weeks later he wanted to get his tonsils back and asked how he might In play he killed his father in effigy and mentioned his bed wetting During the next few months he was afraid to leave his mother during the interview but five weeks after the operation he could verbalize his castration fears and his wish to have as big a penis as his father He was reassured about castration and in the following interviews appeared happier and more aggressive poking mother's umbrella at everybody He played out the T&A using a sister doll as an object of operation enemas and dousing

His mother described him as being more infantile at home during the first two months having many nightmares and speaking of castration Mother wondered why he took her threats so seriously including such as I'll break your legs off if you don't stop running around He talked about his hospital experience in detail and acted it out with his sister After eight weeks he seemed more relaxed and mother reported increasingly better adjustment greater independence and decrease of bed wetting He was seen in therapy for eight months after the operation

Two years after T&A he had a herniorrhaphy at another hospital. The nurses commented on his good co-operation and cheerfulness. His psychiatrist went to visit him. The patient spoke freely about this operation which seemed devoid of the castration fear, which had been so apparent previously while he was at the height of his oedipal conflicts.

Other children expected that the operation might change them from a boy to a girl or vice versa.

Rita, age thirteen, called "honey" by her mother, is the oldest of three girls. Her father died of cancer of the throat when she was nine years old and since then the patient has taken care of her mother. On admission the patient had to calm her mother who was extremely anxious about the operation, asking whether children ever died from T&A. Preoperatively, Rita told the psychiatrist that she missed playing baseball with the boys and how much she would like to be a boy and wear blue jeans. But she was glad she was a girl when it came to singing. She finally brought out the fear that tonsillectomy would make her voice sound like a frog and that she did not like the idea of having a deep voice like a boy. The day after the operation she fainted in the bathroom when she looked at her face in the mirror.

This patient had taken over the role of her mother's husband. Her ambivalence about her femininity, we felt, determined her special fear of the consequences of the operation.

Another meaning of the operation was *giving birth*. While this was found predominantly in girls, we found it also in a few of the younger boys.

Donna was a chubby five-year-old girl who had one older sister and a twin brother. She explained to the psychiatrist that her mother wanted one boy. She, therefore, made Donna a girl and her brother a boy. She did this by "cutting his off." When the psychiatrist wondered about that, she stated her mother cut her brother's hair off. If she had cut Donna's hair off, Donna would be a boy, too. But her mother didn't want two boys. The patient was glad she was a girl because when she grows up she will be a nurse. Three months later the patient remembered the T&A and when asked where the tonsils were located, she said: "You know, right here in the belly," pointing to her abdomen. They cut open her belly and took them out. She didn't know why there's no mark or cut. She then referred to her doll as her baby, gave the baby a name, and said her mother bought it in the hospital. During the interview with the psychiatrist she made several drawings. The two which most clearly illustrate her preoccupation with pregnancy are included (see Plates I and II, p. 140).

Occasionally the child identified himself with someone who had undergone a different operation. Here the expectation of the T&A was based on the child's fantasies about the other operation. Thus, a seven-year-old girl indicated she expected her throat to be cut from ear to ear,



PLATE I

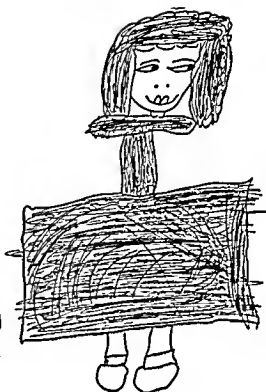


PLATE II

which was her idea of the thyroidectomy her mother had during the past year.⁹

Although T&A is not as common as it formerly was, in some families it is taken for granted that each child will have it in the course of growing up. In such cases the child often looked forward to T&A as a kind of *initiation rite*.

In discussing the children's conceptions of the tonsils, we have already indicated that the T&A may be regarded as a form of *exorcism* or as *punishment*.

There were quite a variety of theories encountered among the children as to how the operation would be performed. There was speculation as to whether scissors, wires, knives, or pliers would be used to remove the tonsils. Some thought they might be burned out. One child insisted that no instrument would be used, but that the ether would melt them away. One very aggressive, destructive boy gave the following account of what would happen:

Dickie,¹⁰ age nine, said that the doctors would cut his nose off with a carving knife, take the adenoids out and then put the nose back on again. He managed

⁹ *Ibid.*

¹⁰ *Ibid.*

to see children in the Eye Ward and stated: "The kids in the other room have no eyes; instead they have bandages on their eyes." He told his theory about the removal of the nose to a girl patient and asked her whether it was true. She indicated her disbelief, but he maintained that it was so. After the operation, he was more quiet than before. He pointed to his nose, saying, "It is okay. They didn't cut it off." He showed his tooth and wiggled it and complained that the doctor bent it. Evidently the castration fear had now been displaced to the tooth.

SURVEY OF THE TOTAL GROUP

Of the 143 children in the study, 80 were boys and 63 were girls. The age distribution of these children is given in Table I. It can be seen that the greatest occurrence of T&A's was during the ages of five and six.

TABLE I
AGE DISTRIBUTION OF PATIENTS WITH T&A

Age	NUMBER		
	Male	Female	Total
Under 3	3	2	5
3	9	3	12
4	9	6	15
5	15	14	29
6	8	9	17
7	8	8	16
8	6	6	12
9	5	5	10
10	6	3	9
11	5	1	6
12	4	1	5
13	1	3	4
14	1	2	3
Totals	80	63	143

Focus of Anxiety

The four main foci were: the separation from the parents and exposure to the strange hospital surroundings, the anticipation of the narcosis, the operation itself, and the fear of needles. Frequently the

child had more than one focus of anxiety. We attempted to determine the main foci for each child on the basis of his play, ward behavior, spontaneous questions, and other verbalizations.

We found that the focus of anxiety shifted with age. This is graphically represented in Figure 1, where we have divided our patients into four approximately equal age groups. It can be seen that anxiety about hospitalization and separation is greatest in the younger children. This shifts to the operation and narcosis, the latter with its threat to self-control and consciousness being greatest in the oldest age group.

FOCUS OF ANXIETY FOR DIFFERENT AGE GROUPS

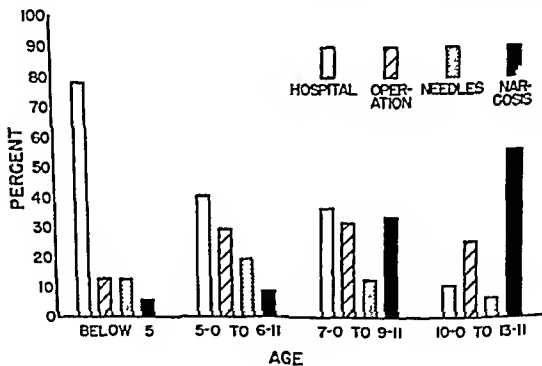


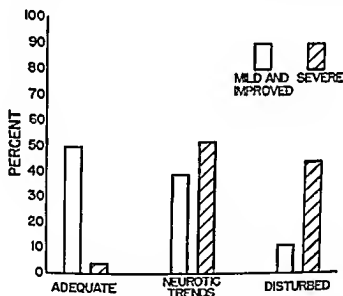
Fig. 1

Effect of Operation

Although the T&A experience seemed to arouse considerable anxiety in practically all the children, the majority seemed to be able to master and integrate the experience without any serious emotional consequences. In some, however, we found that striking changes in behavior occurred, often accompanied by the appearance of symptoms which tended to persist for months and even years after the operation. On the other hand,

there were a few cases where definite improvement in emotional adjustment seemed to occur following operation. We grouped our cases according to their postoperative reaction. Those with marked or persisting sequelae were called SEVERE; those with only mild or transitory reactions were called MILD; and those who showed improvement were called IMPROVED. We had sufficient follow-up material on 136 of our 143 cases to classify the postoperative reaction. The relative incidence of each type of reaction for both sexes is shown in Figure 2. It will be seen that the SEVERE reactions constitute about 20 per cent of the group. Little difference between boys and girls was noted.

RELATION OF EMOTIONAL ADJUSTMENT TO POST-OPERATIVE REACTION



EMOTIONAL ADJUSTMENT

Fig. 2

A total of 25 postoperative reactions were classified as SEVERE. These included a wide variety of disturbances which are listed in Table II. Of the 25, 13 were boys and 12 were girls. A brief description of their postoperative reactions is given in Table III. Most of the children in this group are discussed in more detail elsewhere in the paper.

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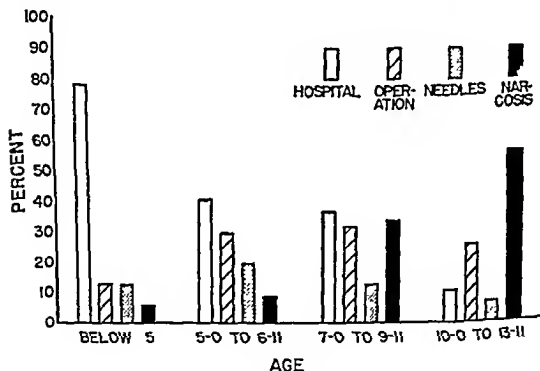


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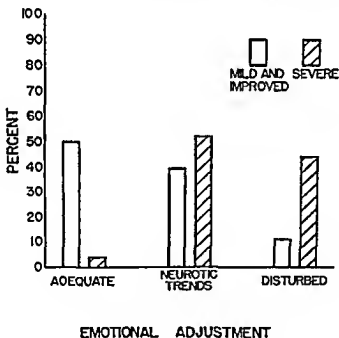


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TABLE II
TYPES OF SEVERE REACTIONS

- A Eating disturbances
 - Overeating
 - Undereating
- B Sleep disturbances
 - Screaming, nightmares
 - Difficulty in going to sleep
- C Speech disturbances
 - Voice change
 - Refusal to talk
- D Tics and mannerisms
- E Fears Hospital, white coats, bodily, death, etc.
- F Regressive behavior
 - Increased dependency
 - Wetting soiling, etc.

Relation of Postoperative Reaction to Age

Our findings indicate that the incidence of severe reactions was fairly equally distributed among the age groups. David Levy (1945) found among his patients that operations were more frequently traumatic among children under the age of three. There were too few cases in our group to permit us to test this observation. We observed only five children below three years. Of these two had emotional disturbances preoperatively. One was a boy of one year, eleven months, who had temper outbursts with head banging. We were able to obtain only a single follow up one week after the operation. He was friendly to the psychiatrist, but his mother reported that he had had nightmares the first two nights after the operation. Bowel and bladder control, however, had improved during the week. This "improvement" could have been a sign of his increased anxiety following operation.

The other was a two-and one half year old boy with whom an early attempt at toilet training had been unsuccessful, and he still soiled at night. He also banged his head when angry and constantly clutched a diaper. We were not able to get any follow up information on him, but the day immediately after the operation he cringed at the approach of anyone in a white coat. His speech was indistinct and his mother commented that he appeared different and did not seem to recognize her.

The other three included two girls and one boy, all between the ages

TABLE III
DESCRIPTION OF SEVERE REACTIONS

Age	Sex	Postoperative reactions
4	F	Eating difficulties
4	F	'Not like herself', dependent, regressive
5	M	Overeating persisting nightmares, increase of enuresis
5	M	Change of voice
5	F	Persisting fears of hospital, nightmares Operation complicated by hemorrhage for 4 days, requiring transfusion
5	M	Adenoid voice for 6 weeks, more anxiety, regression
5	M	Increase of fears nightmares
5	F	Eating difficulties nasal voice
6	M	Uncommunicative night terrors lasting several months
6	M	Did not eat for 4 days increased restlessness
6	F	Nightmares refused to eat
7	F	Agitated, depressed, fearful produced sores on arms and face by picking and scratching Five days later returned on account of nose bleeding, which we suspected was the result of her picking at her nose No later follow up
7	M	'Scrapping' of throat, twisting of neck
7	M	Increase in sleep difficulties grimacing, increase in fear of death
8	F	Increased dependency on mother and fears
9	F	Since appendectomy at 5½ fear of doctors and hospitals, would not eat for 3 days 2½ mos later, changed from cheerful to withdrawn, eating poorly
9	F	Severe abdominal pains night terrors, refused to talk about T&A for 2 wks No further follow up
9	F	<i>Obesity</i>
9	M	Nightmares panic of needles and dentist
10	M	Hysterical aphonia and refusal to eat
10	M	Nightmares phobias throat clearing
10	M	Refused to eat or talk, increase of hypochondriacal fears
11	M	Increase of hypochondriacal fears
13	F	Regressive behavior Refusal to return to hospital
14	F	Delusional ideas about tongue and nose

of two and one half and three years One of the girls was seen only once, one week after the operation, and nothing unusual was reported The other girl developed diurnal incontinence which lasted a short time She also was afraid of a beauty operator in a white coat and two years later

cried at the dentist's. Whether the last was associated with the T&A is uncertain. The boy was followed for fifteen months after the operation and no untoward reaction was noted.

Relation of Postoperative Reaction to Preparation

We did not have enough information on our children to determine if preparation was really adequate in the sense of inner preparedness. However, where the parents made a serious attempt to explain to the child what he might expect in the hospital, preparation was classified as **ADEQUATE**. Where no information was given or was incomplete in essential details, it was classified as **INADEQUATE**; and when the parents deliberately misinformed the child, it was called **MISLEADING**.

We have already seen in some of the previous case descriptions that misleading preparation tended to increase the child's feelings of insecurity. Nevertheless, when we considered the group as a whole we did not find that preparation was a decisive factor for the postoperative reaction. In Figure 3, those cases of **SEVERE** reactions are compared with the remainder of the group in the preparation they received.

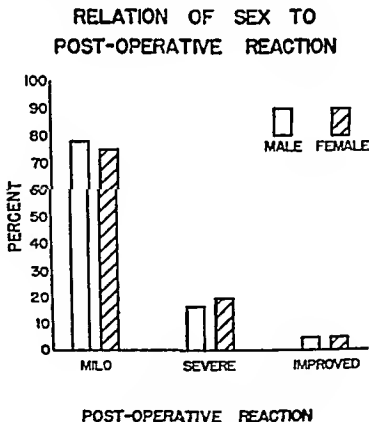


Fig. 3

The slight differences between the two groups are not statistically significant. In evaluating this finding it must be remembered that our children were all seen by a psychiatrist prior to operation. Although his function was chiefly that of an observer, the fact that he encouraged expression of feelings and answered questions may have compensated for the lack of preparation. Although preparation in terms of information did not seem to be a decisive factor in influencing the sequelae to the T&A, intensive study of a few cases demonstrated the importance of inner preparedness.

Relation of Postoperative Reaction to Preoperative Personality

Finally we tried to find out if there was any relation between preoperative emotional adjustment and the postoperative reaction. A child was classified as ADEQUATE where emotional adjustment was basically normal with perhaps only a few minor problems. Where clear cut evidence of neurotic traits or symptoms existed—e.g., enuresis or sleep disturbances—the child was regarded as having NEUROTIC TRENDS. Where the symptoms were severe or crippling with evidence of arrested personality development we classified the child as DISTURBED. These ratings were made on the basis of the anamnesis and the psychiatrists' observations, independent of our knowledge of the postoperative reaction. There was sufficient information available on 130 children to classify them in this manner.

The children with SEVERE postoperative reactions are compared with the others in Figure 4. It can be seen that there is a much greater incidence of DISTURBED children in the SEVERE group. While there was a significant number of children with neurotic trends in this group, there was only one child whose preoperative adjustment was considered ADEQUATE. This was a five year old girl who had to remain four extra days in the hospital because of a postnasal hemorrhage and other complications. These findings suggest that the T&A is not likely to be a harmful experience, except in those cases where at least some neurotic traits pre exist.

SOME ASPECTS OF SEQUELAE

Normal Reactions

The majority of the children we observed had mild reactions for one week or ten days following the operation. They were demanding, irritable, or depressed, had occasional nightmares or other sleep disturbances. These symptoms we, as well as David Levy (1945), regarded as normal manifestations of assimilating the experience. After this initial period, some children tended to suppress the experience, and adapted well on the surface, although many of them betrayed anxiety in their dreams of being chased, cut, tied down, drowned, etc. Other children seemed to integrate

RELATION OF PREPARATION TO POST-OPERATIVE REACTION

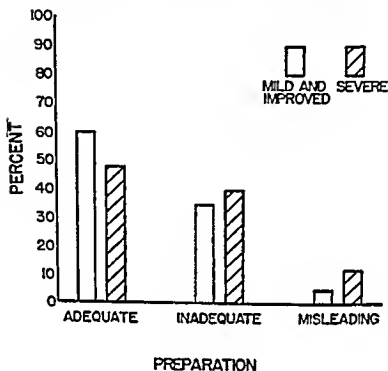


Fig 4

the experience by discussing it especially with contemporaries or younger children, informing them either in a reassuring or in a frightening way, and by repeating it in play

It is our impression that these children who worked through the experience are less likely to have later reactivation than those who adapted by suppression

An example of a child who handled her anxiety adequately seemed to be

Mary, age three and one half was the youngest of two children in an Italian American family. Economic stress and problems of the mother (rheumatic heart disease) did not particularly affect her. Mary liked nursery school. She was very close to her mother who however did not prepare her for the operation. Two years ago her brother had a tonsillectomy without complication and probably he told her about the experience.

Hospital Observations

First day—At first Mary asked for Mommy and wanted to go home but soon engaged in play with her dolls. She related easily to the psychiatrist and to other

children on the ward. She became restless but quieted down when the psychiatrist fed her. She suggested that he eat her and showed him her belly. She then wished he would come home with her. They would eat and go to bed. She mentioned that she was having a tonsillectomy very casually. She spoke about her brother. He is bad, he is the bad one, not me. I help mother.

Postoperatively—Mary played in her bed, said her throat was sore but was not crestfallen. She waited for her mother to come but played readily. She said that she looked forward to eating at home, however she accepted a lifesaver with pleasure. When the psychiatrist left she seemed disappointed and kissed him good bye without crying. She agreed to come back for a visit. When her mother came to take her home, Mary was glad to see her but also was concerned that mother did not have her eyeglasses.

Follow up

One year—Mother said Mary got along very well after the operation. She stayed in bed for a few days and enjoyed the attention and the toys she received upon returning home. Mary compared notes with her brother who had had his tonsils out in another hospital. She had gone to camp meanwhile and had done quite well. She did not mind coming to the hospital for follow up.

Mary latched onto the psychiatrist (different from the previous one) with no hesitation. She remembered the thing over my face (ether mask). Asked what it smelled like she replied, Like perfume. Asked why she had them out. So I could get a doll house. She played out a scene with dolls in which a verbal battle ensued between the girl and the nun with the nun's being ordered around and told off. Asked what had been wrong with her tonsils she replied, They tickled my tongue but they don't no more. She painted a snake looking at a duck.

This child had resources facilitating adaptation and integration. The relationship between mother and child was secure and warm. She had reached the developmental stage according to her age without neurotic manifestations. Although unprepared by her mother she had apparently gained knowledge on her own. The child could express her anxiety quite freely and the defense mechanisms she used were adequate, e.g. she was disconcerted when her mother left but would transfer her feelings to substitutes easily. She then handled her anxiety in a way comparable to humor which adults use in a frightening situation—by her coquettish and joking manner with the psychiatrist. The jokes seemed to allude to her fear of being eaten up and to her oedipal wishes. This seemed to arouse some guilt feelings which she quickly projected onto her brother and reassured herself that she helped mother. She seemed to take the operation and the consequent throat pain quite realistically whereas some children complained a great deal about the soreness of the throat to a degree which seemed due to an overlay of anxiety. She could take a candy and

enjoy it while others were afraid to hurt their throats by eating. Concern of having lost something seemed expressed in her worry about mother's missing eyeglasses. At home she apparently could freely talk about her experiences. Another separation from home three months postoperatively (camp) was tolerated comfortably. In a play interview a year after T&A she indicated some anxiety connected with the operation through a painting of a snake looking at a duck. In all our contacts with Mary she had an appropriate degree of anxiety, sometimes increasing through guilt feelings when instinctual wishes were expressed and immediately being attenuated by successful defense mechanisms.

Except for one passive boy, all children who played the doctor game took over the active role, being either the surgeon or the anesthetist, operating on a doll or a playmate, or giving needles to the patient. In dreams, however, most of the children were the victims of an attack. In respect to dreams there appears a difference between children and adults. Helene Deutsch (1942) pointed out that in a traumatic neurosis the traumatic situation is usually repeated in the dream; whereas in her postoperative patients she has "never seen such a direct repetition of the traumatic experience. If the dream contains direct references to the operation . . . , the dreamer usually appears in the active role. . . ." With our children the dreams usually dramatized the operation in easily recognizable form. References to the operation in fantasies and stories repeated the situation in a romanticized way, similar to the dreams. In play, however, the roles were reversed and the child performed the operation. There is one other difference of children's reactions to those of adults in regard to surgery: The adult, as Helene Deutsch describes it, carries out in postoperative dreams the action usually against a person of authority, a father figure. In so far as the children's doctor games are concerned, the victim is always another child, a contemporary, or more often a younger child.

Symptom Formation

In a number of children, anxiety manifested itself in symptom formation.

In some, anxiety was focused on and limited, like a phobia, to doctors, white coats, nurses, hospitals, or ether, associated with a reluctance to leave mother or go outside the house.

Sequelae in others consisted of tics or conversion symptoms centering around the area of the operation (mouth, nose and throat).

Richard, age ten, who had undergone a previous T&A at the age five, and was concerned about his dog who had swallowed a fish hook and had his mouth torn, is described in detail by Dr. Samuel Kaplan (1952) as a case of hysterical aphonia following T&A. We found that at a recent follow-up interview, Richard

had no speech difficulties but an atopic dermatitis and a general apprehensive ness He still has the notion that doctors will take up knives and cut him He remembered that for some time after his operation he was scared that he would not be able to talk

Edward, an asthmatic boy of five had a high pitched voice for several weeks His mother kidded him for having a girl's voice It is our impression that it was rather a baby's voice His symptoms seemed largely determined by his identification with a three month old brother of whom he was very jealous

The majority of the children had some *eating difficulties* during the first postoperative days, with improvement in appetite as they recovered from the operation In nine cases we found marked eating difficulties lasting for weeks or months Five children began to overeat, and two of these developed *obesity*

Camille, age nine a compliant overcontrolled girl knew her mother wanted the T&A to improve her hearing and to make her eat better She mainly talked with the psychiatrist about death She had a dog in fact two Both of them had died The cat also died a year ago after being bitten by another cat in the neck She also had a brother who died when he was young (death of infant brother occurred when patient was four years old) She froze up when the operation was mentioned and watched with horror another girl spitting blood Two months later her strongest recollection of the hospital stay was spitting blood after waking up Three and one half years later Camille was at least 50 pounds overweight to the chagrin of her likewise obese mother Whereas Camille was punished preoperatively for not eating enough she postoperatively could not be stopped

Four years after T&A she appeared shy scared and mentioned that she had been frightened at the thought of coming here She had been at the hospital a couple of times since her T&A I always dream afterward The only such dream she remembered was two nights ago A girl was being attacked by her father who was a vampire He was going to suck all the blood out of her (The patient's father had left the family five months prior to the T&A to live with another woman)

At the time of operation this patient was afraid of dying remembering her brother's and her dog's deaths and identifying herself with the cat who was bitten in the neck From the beginning there was an emphasis on losing blood At the age of thirteen the fear of being killed was more definitely in the form of being attacked by father who sucks out the blood We assume that her overeating was related to the fears of death and sexual attack.

Anxiety States

Camille belongs to a group of children who prior to operation were burdened with apprehensions of mutilation and death They reacted

to the T&A with persisting heightened anxiety. We will report on four of them in detail to discuss their dynamics.

Francis, age eleven, was described as an overactive boy with temper outbursts, resembling those of his father, a reformed alcoholic who occasionally had epileptiform seizures. Francis had a long medical history, with numerous injuries to his genitals and hands. At two and one half he was scratched by a cat on his penis and appeared terrified. Around that time he was circumcised on medical advice, followed by a period of enuresis. At four he was treated for hematuria, at six for pain in his groin, diagnosed as due to lymphadenopathy, at nine for albuminuria and for a lacerated left hand. His mother noted that the testicles, particularly the left, were frequently missing from the scrotum and that he complained of pain in his penis. At ten his hand was caught in the wringer of a washing machine. The wound was closed under nitrous oxide anesthesia and Francis was discharged after two weeks of hospitalization.

On being admitted for T&A, Francis kept aloof, reading the same comic books over and over. He assured the psychiatrist he didn't mind the operation since his older brother had it when he was three and he, himself, had ether before, pointing to the long scar on his arm. He accepted the anesthesia most obediently. Postoperatively, however, he appeared extremely depressed. He sobbed for hours, covering his head with a blanket, terrified because his throat hurt. Two weeks later he was noncommittal, but two months after, he expressed how miserable he felt for five days and how he could not eat or talk. Then he gained 6 pounds. He mumbled that for the time being he was all right, but later on will have to have his tonsils out again. His mother told him, so he says, they will grow back and one has to take them out before he is twenty-one. Taking them out after twenty-one may be dangerous; he may even die. His nineteen-year-old friend said his tonsils will grow back again and if they don't take them out before he is twenty-one, they will grow and grow and choke him. While he said they will grow and grow, he drew a single large elongated object in the air with his fingers. He looked worried and mentioned that a big fat boy in school had kicked him down here, *pointing to his genitals. It is a very dangerous thing to be hurt there. One may die. It was bleeding. It was terrible.* The same day his mother brought him to the medical clinic, as he was kicked in the groin by another boy. The patient complained to the examining physician about tenderness in both groins, penis, and testicles. There were no local signs of injury. Five months postoperatively he was rushed to the emergency ward because he breathed carbon monoxide fumes from a refrigerator.

In this case castration wish and fear, accident proneness and conflict about masculinity were strong before T&A. The operation fitted into his fantasy of castration and death—the tonsils representing the testicles which he knew were not at the right place. He expects more to come; he was not satisfied that it was done. The wish for and fear of castration continued with great force postoperatively.

David, age ten was a forceps baby and had been hospitalized at five months of age for four months because of purulent otitis media at the age of four and one half for mumps and for pneumonia at the age of seven he was hospitalized for scarlet fever and for a month following discharge he cried continuously at night This happened shortly after his mother separated from his father because he was irresponsible drank ran around The patient was very attached to his father although his father was very strict to him The patient continued to ask for his father Around the time of separation he began to wet his bed occasionally and to have nightmares in which someone drowns or is hurt in an accident Ever since he was afraid of the dark and wouldn't sleep before mother goes to bed During the past one and one half years David was present when both maternal grandparents fell sick and died

On admission David at first denied any fear assuring himself that he won't feel anything because one gets ether and that he had had gas before at the dentist's He thought how it would be to get on the table get ether get clamps in the mouth to keep it open and long scissors to take them out Something might happen to him When he plays he thinks he might die no reason for it

I heard one little girl got killed a truck ran over her He is afraid something might happen to someone who lives in the house and also to his father He dreams often of scary things He became anxious when he had to undress and cried when he had to wear short pants instead of long trousers Mother remarks that since age six he has insisted on long pants On the ward he got more tense biting and sucking his thumb mentioning that in case you go into the Army you can go blind

David seemed comforted after the priest's visit and passed on to a little girl that the priest had told him If the doctors make you die you have communion in your heart (Later on he admitted that the priest said no such thing) In the operating room he asked to see the instruments He tried to grab the ether cone cried Mama and Lord then struggled against the anesthesia

Immediately postoperatively he cried constantly for his mother lying in the corner of his bed in semiflexion complaining that the ether had frightened him

I felt like I was choking When he woke up he was scared that he wouldn't be able to talk He anxiously confessed that he didn't go to church regularly anymore

Two weeks postoperatively he seemed depressed and timid His mother reported that he had been weepy since he came home and for the first four days had refused to answer any question about the operation A month later the mother still complained of his whining and of his not behaving any more like a big boy He seemed to act out something while asleep e.g. sitting up in bed fighting taking off his pajamas throwing them into a bureau His wish to go back to New York where his father lives was expressed more frequently He spoke of visions during ether and how he had felt dizzy after it He seemed concerned that he was still under the influence of ether because he forgot many things and didn't know what he was doing at night except from his mother's stories He then mentioned they didn't take his tonsils out I still can see them —pointing to his uvula

Six weeks postoperatively he was admitted for meningoencephalitis at another hospital, and recovered within two weeks. Six months postoperatively he still seemed anxious and quite preoccupied with the operation. He mentioned that he saw his dog's tonsils, on the side of the neck. "Do dogs have their tonsils out. . . ?" "It might kill them because they can't swallow after the ether."

One year postoperatively he still seemed shy and restless; the content of the interviews revolved around the old theme of mutilation and death. He announced that he wanted to be a pilot later on. "I don't want to be a butcher. I know a butcher in New York who chopped his finger off. I don't know when he did it, but it was off when we used to live there." He likes to paint war pictures. He wanted to know how ether makes you sleep. "How long does it make you sleep?" It seemed just three to four minutes to him. He seemed to allude to the feeling that he was still under the influence of ether. "I wish I didn't wake up at all, because my throat hurt. . . . If you have them out, you don't have to have it again. You don't have to go through it twice." He seemed anxious, hoping for confirmation of his opinion, and inquired why they put a needle in the bottom of another boy to make his temperature go down. One got the impression that an attack on the rear would be even more frightening than another operation. From his mother we learned that the patient continued to have episodes at night, in which he acted wildly agitated. They always came when he was upset during the day. He had none during summer vacation. The mother attributed those nightly episodes to the T&A, because he screamed about knives and people coming to cut him up. He was doing very well at school but was irritable at home and afraid of the dark. He would not go to the bathroom by himself at night. Lately he woke up his mother two or three times a night to take him to the bathroom and when he got there he didn't seem to have to go. In the morning he takes an hour or more to clear his throat. Physical examination revealed no ear, nose, and throat pathology to account for this symptom. Neurological examination was negative.

Before operation David had hypochondriacal fears which we felt were based on his struggle against the wish to submit to the cruel father—to be castrated and annihilated. He covered up his passive, feminine tendencies by insisting on long trousers and athletic activity. The operation seemed to give him a taste of what he unconsciously wanted and intensified the basic conflict. He seemed to expect, wish, and fear a more devastating experience.

Paul, age seven and one half, had, during his neonatal period, a bilateral otitis media which ruptured spontaneously and he was cranky for the first weeks. He seemed dissatisfied, cried a great deal, and had a feeding disturbance. He suffered from recurrent running ears until he was two and a half years old. When he was seven months of age his father left for military service, and in spite of the father's frequent visits, the patient did not seem well acquainted with him. When his father asked him where his father was, Paul would point to a picture on the mantelpiece. When Paul was six years old the paternal grandfather

visited the family and one week after he arrived, he died suddenly of pulmonary infection. The grandfather had gone into coma in the late evening and oxygen equipment was brought to the house. The grandfather died in the early morning. Paul was observed by his sister going into the room and taking the sheet off grandfather's face. The patient seemed not particularly disturbed, but several months later he developed a habit of coming into his parents' room in the evening complaining he was afraid to sleep and wondered what happens when people sleep. The parents had the impression that for Paul sleep was related to his grandfather's death. When guests would comment on the patient's noisy breathing at night, Paul would become upset and his parents felt that he was reminded of his grandfather's labored breathing during the night he died. Prior to his T&A, for which he was well prepared, Paul showed at home a great deal of bravado and was overactive and quarrelsome.

On admission to the hospital, he appeared tense and jittery. He occupied himself by completely covering many sheets of paper with bright colored crayons. This was done very forcefully so that many crayons broke. He asked all types of questions in regard to the equipment in his room. He reacted with hyperactivity to the sedative the night before the operation, throwing himself about in bed. On the way to the operating room, his chief concern seemed whether they were going to remove a tooth at the same time. When told this would not be done, he appeared rather disappointed. He asked every conceivable question about all of the anesthesia equipment that he saw, tried to delay the narcosis by asking questions, but went under peacefully.

Postoperatively he was proud of his co-operation with surgery and the fact that he held the ether cone over his nose himself. His drawings were full of orange and red skies. After a few weeks he regularly drew pictures of a house with a large red chimney. He made clay models of automobiles, all hot rods, accurate to the last detail with special interest in large hood ornaments. After the operation he had difficulty falling asleep and would play his bedside radio for hours. The parents noted that Paul made tremendous efforts not to fall asleep. On questioning he described that as soon as he would fall asleep he would begin to hear noises and then he would immediately wake up frightened. It was several months before he related these noises to the noise he heard in his ear during anesthesia. After talking about that for some time he stopped complaining of it. What also grew worse postoperatively was his coming into the parents' bedroom, crying he was afraid to fall asleep because he might die. He would worry about the future, especially the year 2000, or he would think of a date and wonder if he or the other people he knew would be alive at that time. Once or twice he discussed this in relationship to the death of his grandfather. On hearing about someone's death, he immediately wondered how the person had died.

Another symptom, grimacing, appeared much stronger postoperatively. This symptom seemed to be related to two experiences he had at age five and one half. At that time Paul annoyed his dog by shooting at him with a cap pistol and the dog bit Paul's upper lip through, so that it had to be sutured. Around

that time his sister got teeth braces and toyed with them by making grimaces with her lips

Another postoperative difficulty was a provoking negativistic attitude toward his father. He once stated that his father looked at him as though he were going to kill him. When asked whether he was not angry at his father himself, the patient with a burst of laughter said he often felt he would like to smash his father's nose right through his face. After this admission he seemed less provocative and less likely to cry when scolded.

One year postoperatively he read almost one biography a day and became the class expert on American history. He knew the day of birth and the day of death of practically every American of note. At the same time he got passionately interested in riflery and archery. His anxiety and his symptoms gradually subsided but a striking increase occurred when, one and a half years after the operation his grandmother, who was living in the household, fell in the bath tub and broke one toe. Paul frequently went to her room, was visibly disturbed, would not sleep, and made grimaces. After about two weeks these symptoms subsided.

Steven, age ten, was a shy, pale, undernourished, and subdued boy. His father was a seaman who used to come home only occasionally. He liked his children and favored the patient, but became abusive when drunk. Mother impressed us as being warm, overprotective, anxious, and worried about her marriage, financial difficulties and her kidney disease. When patient was three years old a younger brother was born. Since then Steven has been enuretic and a poor eater. At the age of six he was struck by a car. Shortly afterward another boy pushed him and he fell. This resulted in a ruptured kidney for which he was hospitalized three months involving many catheterizations. During the same year the family's house burned down and the parents separated. Nothing was heard from the father since. From the age of eight on, Steven had frequent colds and missed school often.

On admission Steven seemed reserved and overcontrolled. He did not sleep much during the first night and remarked the next morning that at 7 A.M. a bell rang like a church bell. In the operating room he lay motionless staring. He denied fears, assuring himself that he had had ether before. He took the anesthesia quietly and obediently.

Postoperatively he appeared depressed and cried. I vomited blood. Two weeks later he appeared dejected, moving slowly, talking in a very low voice. He mentioned that they didn't know where his father was and that the father didn't know the family's address because their house burned down one and a half years ago—while the patient was at the hospital for a check up. When they came home they found it burned down. Everyone was saved except the patient's dog which was burned to death. He had been vicious and mother wanted to give him away. But the patient liked him very much. Another dog, patient's favorite, was run over by a car. Once father brought patient a guinea pig. A few weeks later it got a fit and died. Patient also had mice which his father had given him. They died one after another.

The mother reported that the patient would not eat for about ten days after the operation, nor would he talk. He said he felt that something was stuck in his throat. Mother thought he kept his feelings about the operation hidden except for praising the nurse because she brought him a radio. While his reaction was a very severe one, the patient seemed to recover three months later, steadily eating better and gaining weight.

These last five patients—one girl and four boys—have certain features in common. They had been sick many times, from early childhood on, had met with accidents or surgery, and had experienced the death of relatives or pets. These events seemed to have left them with the feelings 'It happened before, so it will happen again,' and 'what occurs to others will occur to me too'. Four had cruel, threatening fathers, to whom they were deeply attached. One (Paul) was in passionate rivalry with his father and projected his own aggression on him. These children seemed to provoke accidents or fights unconsciously. Any threat to the body increased their fears. They repeated the operation in dreams in the manner of a traumatic neurosis. Their play and talk betrayed their preoccupation with the operation only in an indirect way, and hardly referred to it directly in the way the majority of the children assimilated the experience. The dynamics of these children confirm the statement of Helene Deutsch (1942) that when the child is burdened not only with a sense of guilt because of forbidden masturbation but also by death wishes against some person near to him, the expectation that his own death will result from this attitude is a powerful factor in both the early and late fears of operation.

However, other apprehensive children, with a history of traumatic life experiences, felt a relief after T&A: some because the anticipated annihilation did not occur, others because their need for punishment was fulfilled.

Elizabeth, age thirteen, had hysterical character traits, hypochondriacal concerns and a nervous stomach preoperatively. Two years prior to T&A her father had died suddenly and her mother suffered a nervous breakdown. One year ago her older sister went into a depression. On admission Elizabeth talked incessantly and referred to her father's death. Immediately after operation she felt relieved and appeared serene. Afterward her appetite improved. Two years later she appeared as an overly made up coquettish adolescent, mainly interested in her frequent dates with sailors. She remembered that her throat was sore for two weeks, but it was worth it, the ether was not bad at all. She did not believe that they really took her tonsils out.

Carol,¹¹ age six, had a father who drank heavily but a warm stable relation

ship with her mother. When she was three years old her hand got caught in a wringer. Six months before T&A a younger sibling died of whooping cough and pneumonia. Carol on admission talked freely with the psychiatrist about her fear of death. On awakening from anesthesia she expressed relief that she did not die.

Mary,¹² age five and a half, had been an anxious child, clinging to her over protective mother, very conscious of her mother's severe illness (lymphosarcoma) which had necessitated several emergency admissions. Mary had been hospitalized a few months prior to T&A and at that time raised the roof and vomited when her mother left. When she came for T&A, Mary was frightened, and not communicative, but acted out her fears with her doll, indicating that she believed illness to be the result of naughtiness. She expected her throat would be cut. Postoperatively she described her experience in great detail and wanted to take her tonsils home in a jar. The first night she had bad dreams and did not sleep well but afterward did not appear anxious and started school without difficulties.

In comparing this group of apprehensive children with those who had severe reactions, we felt that there were both quantitative and qualitative differences in their anxiety. In the severe group there was a special multiplicity of traumatic events. Their anxiety appeared greater and seemed to be related to their highly charged relationship with the father.

Obsessional Children

In a few obsessional children we observed the breakdown of their control and their reaction formation as sequelae.

Eileen, age eight, was described by her mother as a good girl, always concerned about cleanliness. She could not stand dirt and changed her clothes three or four times a day. She had asthma since she started school. Occasionally she had temper tantrums and complained that no one cared if she died. The mother gave us the impression of being an anxious and tense person, preoccupied with the hysterectomy she had had six weeks before. She was ambivalent with Eileen and preferred the younger sibling, a boy. Eileen's toilet training was started when she was six months old and accomplished by the age of nine months. She had five previous hospitalizations and every disease known to children except diphtheria.^{*}

On admission Eileen looked sad and talked a lot. She asked the psychiatrist to put up the side of her crib so nobody could get into it. She spoke of her tonsils as being "rotten" giving her sore throats and belly aches. She asked many questions. Would she feel anything? would the operation be done with a big, big needle and pliers? would she spit blood afterward? She spat five thousand times when she had her teeth out. Was it true that she would not spit blood

if she could only vomit blood . . ? From the tone of her voice the psychiatrist got the impression that the patient preferred vomiting as an event for which she was not responsible, to spitting as an act of reflecting aggression. She remarked that she would be braver than the other children and was not going to cry. She continued to ask other girls on the ward what would happen. She recited to the psychiatrist

Three little kittens lost their mittens,
And they began to cry,
'Oh Mother dear
We very much fear
That we have lost our mittens'
'Lost your mittens! You naughty kittens!
Then you shall have no pie

and the third verse about the soiled mittens. She fussed about being neat and repeatedly wanted to know what time it was. When given the preoperative sedative, she coughed, sputtered and gagged excessively.

On recovery from the narcosis she screamed, thrashed around in bed, gritted her teeth, and gagged. She became so unmanageable that she was restrained. She vomited all over the place, disregarding the basin and blew her nose without a handkerchief. She had to stay for a third day because she ran a temperature. She seemed completely devastated. Her innumerable questions postoperatively were loaded with concerns about her body, e.g., why did she have a speck of blood on her thigh and a sore spot on the roof of her mouth, why were her eyes sore . . ? She seemed suspicious of what might have been done to her.

One week later, Eileen did not want to talk with the psychiatrist about the operation. She rearranged the furniture in the doll house, particularly in the bathroom and kitchen. She was careful to keep the doll figures separated from one another. After two months Eileen mentioned at home the ginger ale she got at the hospital and the nice doctor. When coming for one of her follow-up visits she was reluctant to leave her mother. She mentioned that last year when she returned from school she did not find her mother at home. She tried to open the door but could not, then she went downtown with a neighbor. Her mother passed her on the street but did not recognize her. (Mother liked to play sadistic practical jokes on her children, e.g., telling them she would leave for good and enjoying the children's anxiety as a proof that they would miss her.) Eileen added, there was a murderer living in the neighborhood and she was afraid to go to the store because the murderer might go there, too. She also was afraid to walk in the street. She then mentioned dreams about murderers, e.g., one murderer walked in the window all dressed in white and scared her. Three years postoperatively we could obtain information only from the mother. Eileen had been sick a good deal, with asthma, requiring hospitalization. Two months ago she had an appendectomy. On the whole mother thought of her as 'kind of nervous'.

Thus obsessional neurotic child had tried to ward off her anxiety by em

phasizing her goodness and neatness preoperatively. When postoperatively she experienced pain, blood, and mucous, she felt overwhelmed. The neat and controlled little girl showed her messiness and hostility.

Other obsessional children had milder reactions

Douglas, age seven, was described as overly neat and very orderly. Mother complained about his stubbornness.

In the hospital *Douglas* occupied himself with constructing houses from a tinker toy, mainly heaping the parts into neat piles. He said he didn't know where his tonsils were but put his hand over his throat and asked whether they would 'snatch them out.' He complained that his two younger brothers ruin his toys so that he locked the toys up. He fingered his genitals and seemed curious about the happenings in the hospital, perhaps wanting to find out where babies come from. The next morning he lay crying in his bed, lonely and upset, missing his mother. He became quite angry at the nurses, threatened to get even with them, ripped his sheet and fingered his genitals. On the way to the operating room he asked a lot of questions.

After the operation he whined, would talk only little in an adenoid voice. He complained that they threw his tonsils in the river and that this is not good. We have only one report on him two weeks postoperatively. He called for the nurse during the first two nights at home but seemed otherwise to get along all right.

Gail, age five and one half, was brought into the hospital by her father since her mother was too afraid of hospitals and of having to leave the child. Mother gave *Gail* a tremendous doll to take along to keep her company. *Gail* clutched her doll most of the time. She busied herself putting the playroom in order, was anxious to wash her hands after the job was done. She was fussy about food, did not want chocolate ice cream. She was anxious to locate the fixtures on the ward door knob shade, etc.—and took everything in she could investigate. She complained that she had lost a tooth and maintained her tonsils will not be taken out, she is only going to have them fixed. She did not want to discuss her tonsils any further, as her father had told her not to be scared and "not to think of it." She much preferred to play with the psychiatrist a game of 'taking a ride.' Shortly before the operation her anxiety mounted.

Postoperatively she cried softly and slept most of the time. During the following ten days at home she complained about having been left in the hospital and she refused to eat. Mother forced her to. She talked through her nose and would not mention the operation at home. Father had to urge *Gail* to go to the psychiatrist at her follow-up interview. She seemed tense, anxious and less spontaneous than preoperatively. *Gail* said her tonsils were thrown away and she would not have to worry about having them out again. After four months she still was eating poorly and slowly, although her general health was better. She was able to tell the psychiatrist that she was afraid of needles and remembered coming out of ether. After three and a half years she had trouble with the letter 'S' in her speech and had mild food fads, but seemed generally relaxed.

Two other examples show obsessional children with little sequelae

Florence, age six was a well behaved somewhat rigid girl described as very good at home controlled with adults but aggressive with other children Pre-operatively she bragged about her being a good girl made herself a leader of the group and poked fun at the crying of others Postoperatively she showed marked regression for two hours acting babyish with her thumb in her mouth Then she resumed her adult role and boasted how well she behaved Two weeks later she did not show any particular anxiety She had told her mother about the operation realistically and discussed it with her sister Six months later she was reported to be still talking about the hospital

*Tommy*¹² was a six year old boy whose mother was very attached to him He seemed to fulfill her wish to be a boy herself She put him under pressure to achieve yet he didn't talk until he was four and insisted on going to bed at seven because he didn't want to get red eyes

On the preoperative day in the hospital he expressed fears of being punished was concerned about being good and played that he was the sheriff His focus of anxiety was the needles and he complained afterward that he got eight needles in the ass This fear of needles persisted three and a half years later

Both Florence and Tommy were able to express their fears in words and play more freely than most of the obsessional children we observed

Aggressive Children

Most of the aggressive children had sequelae for a considerable period of time However these sequelae were milder than with children whose aggression was turned against themselves

Leo aged five and a half was described as a hyperactive aggressive outgoing boy imaginative inventive making contact easily

His mother showed great warmth and affection for the patient She felt nervous and overburdened by her two very lively children and by a lack of money and a duodenal ulcer

Since age two and a half Leo was a frequent patient at the Children's Medical Service of this hospital first because of a limp of the left leg diagnosed as *pes planus* and later for tonsillitis and upper respiratory infections He had four Emergency Ward admissions prior to T&A and those times was noted to be interested and co-operative At camp a year ago he enjoyed himself without signs of fear Three weeks prior to T&A he had been listless at home with tonsillitis and was fretful in the Emergency Ward knowing he would soon be operated on

On admission the patient screamed that he didn't want to stay in the hospital His mother comforted him telling him he would feel better after the tonsils were out Leo kept on crying loudly patting his penis and looking to

mother for reassurance. Mother explained that a week ago he had had a leg muscle bothering him so that he could not get out of bed. She believed that he was afraid that something was going to be done to his leg. After he went with his mother to the ward he continued to protest tearfully.

Three hours later he played with other children, was bappy and active, talked about prison, and asked the psychiatrist to read him a story. He seemed pleased with the whole situation, was entertaining, joking, and had a push of activity and speech. He ate a good deal.

Some time later he found a pair of glasses in his night table and appropriated them. He put them on and off, proudly exhibiting them, refusing to give them up, saying, "I brought my glasses from home." While he proudly announced, "I'm going to have my tonsils out," he closed and opened doors and put the glasses on and off. He turned to a toy motorcycle, commenting on the missing front wheel. When he sat on it, it cracked. He said, "It's broken," and began to hop on one leg, mentioning that his leg hurt and pointing to his groin. Later he appeared shy and quiet, agreed with the other children that one patient who acted like a tornado should be locked in a closet. "Gonna have my tonsils out tomorrow and the next day I'll go home." He made friends with another patient, who was small and tongue tied, and assured him the operation would make him better (which had been mother's way of comforting the patient.) He fought angrily when the nurse gave him an injection. Toward evening he lay in his crib on all fours, much subdued, sobbing quietly, and looked blankly at the psychiatrist.

The next day he was happy to see the psychiatrist, throwing his arms about him, showing off with his glasses, jumping up and down and trying to climb out of his crib.

While waiting in the operating room he was boisterous. "I'll eat you, I'll cut off your head! Don't cut my head off!" He yelled at the attendants. "Sbup up, you stupid thing!" He jumped about, throwing the emesis basin on the floor, wanting to kill everyone and knock down the whole hospital. He protested, "I don't want my tonsils out, I don't have a sore throat. My mother is stupid to bring me here. I'll kill her!" Then becoming playful, he pretended he was an Indian, shooting a medical student and hiding in a tent he made from blankets. He put the ether mask on his face, he's the Lone Ranger. Later the mask was a coffee strainer, baseball mask, hat. He went to the operating room piggy back, without noise or comment. There, he was apprehensive, looking around the room and at the table, saying "Light, put the light on." He refused to be covered by a sheet. Anesthesia started with the patient struggling and screaming, "No don't do that!"

Postoperatively in the hospital he cried during the night for water. In the morning he refused to put on the glasses, saying that they were not his after all. He would not talk, nor look at the psychiatrist. Until four in the afternoon he remained silent and immobile. He then complained about his throat hurting and wanted the psychiatrist to read him a story. "My mother is going to bring me a lot of penicillin. The girl over there is having her tonsils out, too." He

cause of fever, he couldn't go home that day. The next day he was sad, wanted to go home, but was talkative and interested in a toy his mother had brought him. "I'm going home, I'm glad my tonsils are out. My brother had them out,¹⁴ but he cried and cried. I didn't cry."

At the first follow-up interview, two and a half weeks later, he smiled at the psychiatrist, but was reluctant to leave his mother. He insisted on having his brother go with him for the interview, and all posthospital interviews went on in the presence of his brother. He made a house of clay and told of a lady who lived there all alone, she had no food. He asked the psychiatrist to make a boat and provided a man to run it, this man had only one leg and the patient wouldn't add another one.

Four weeks postoperatively he made fishes out of clay and was worried about the swordfish's having a long thing, saying, "It is his mouth maybe. He yelled 'Stupid! Pumpkin head!' at his brother. In both interviews he was unwilling to talk about the T&A or about the glasses, but said he found the glasses in a drawer.

Six weeks postoperatively, when asked about the T&A he said "They put the thing over your nose and wham! —running his hands down his body to his feet. He had vomited and they kept him here a long time. He will kill the bad doctors. When asked whether they removed anything else, he answered 'No well, maybe.' His brother calls out 'his nose' which leads to a big laugh from both boys. Both boys are extremely active and destructive during the interview. The patient says he wants to become Abraham Lincoln with a long black beard.

Three months postoperatively his mother complained that the patient's voice had become different since the T&A, "sort of nasal and husky." The patient insisted that nothing was wrong with his voice, that he was making it sound funny. His brother pointed out the Eye and Ear Infirmary and said that was where the patient had his tonsils out. When the psychiatrist remarked that brother had his out there, too, patient cried, "No he didn't. He's a liar! The patient banged a table fiercely with a hammer, but was careful not to hit his fingers, using a block to guard them.

Four months postoperatively the patient and his brother played house, locking each other in and out. The patient was generally more co-operative and less aggressive.

During the interviews held five months after the operation, the patient was more constructive and said that the psychiatrist should not give his brother a gun because he goes wild. Grownups never get wild. Father won't let patient have a knife until he is grown up. The patient borrowed a knife from the psychiatrist. He used the knife skillfully and obeyed directions. He again emphasized that only he and not his brother had this T&A at this hospital.

Seven months postoperatively his jealousy of his brother was still great, but he was not as openly aggressive toward him. On the whole he seemed well adjusted.

¹⁴ Leo's younger brother had a T&A at this hospital one year before.

This boy had considerable fear of mutilation before the operation and afterward a suspicion that something more than tonsils had been taken away from him. This was masked by an increase of his aggressive behavior. For short periods during hospitalization his façade crumbled and anxiety broke through. In the course of integrating the experience, he first used narcissistic pride in his courageous performance as reassurance against castration anxiety. Later he relied on his capacity to control his aggression which seemed a successful method to decrease his fear of punishment, and a step in maturation.

Constructive Experience

For quite a number of children the operation was a constructive experience, enhancing the development of the ego.

Rosemarie, age eight, was a cheerful girl who made good contact with other patients and felt optimistic about the operation, expecting something will burn out the tonsils.

Postoperatively she complained of pain for several days and would not speak. Her younger siblings asked if her tongue had been removed. When she recovered she established a new status among her siblings. She continued to be interested in the hospital for three and a half years and had decided to become a nurse on our last follow up.

This child had suffered a narcissistic hurt by having pain in her throat, which she thought would not happen to her. Having endured it, however, this gave her the feeling of strength in suffering and the experience was in retrospect one of gaining status and identification with a figure (nurse) who was both an aggressor and a protector.

With others it seemed that the mother's attitude changed because unconscious wishes to punish the child were fulfilled and the child responded positively—as was one of the relevant factors in the case of Frank.

Frank, age three and a half, had two previous hospital experiences including a previous T&A ten months before at another hospital. At that time he cried continuously, would eat nothing and drove the nurses almost crazy. Mother was certain he would be a problem this time. He did not like hospitals and doctors and was disturbed by barbers' white coats. His mother had not prepared him much as she felt he was too young to understand.

Frank was a premature baby, was neglected somewhat as an infant, was always a feeding problem, had infantile speech, had food fads, was negativistic, and wanted his own way. Mother was overprotective, giving in to his demands sometimes and at other times treating him harshly.

On admission Frank was a small, infantile appearing boy with infantile speech. His mother constantly admonished him to be a good boy and to eat. He

got dressed in his play suit and walked around exploring the hall. He ate just his bread for lunch and that very slowly watching his mother all the time.

Later in the day he cried bitterly and wanted his mother. He became panicky when he saw another child receiving an injection. He could not be reassured but asked for his mother. He cried whenever a nurse entered the room. Frank played with some of the other children intermittently.

Late in the afternoon and the following two days at the hospital he was subdued. He cried, "Want Mommy want Mommy—when is Mommy coming?" He was unable to use help and reassurance from the psychiatrist.

On follow ups the mother reported that he had been a different child since T&A. Everyone had noticed this. His appetite and disposition changed for the better. He ate a full meal as soon as he came home which surprised her. For the first time in his life he slept well. He spoke better but his mother was upset because he seemed to be taking on an Italian accent putting a *s* on the end of everything like "I wanta my bike." (They lived in an Italian neighborhood and he had an Italian friend.)

It turned out that the mother had treated him quite differently since his operation. She let him play with other children whereas before she had considered him too sickly to go outside. There were signs of postoperative anxiety e.g. he would not drink beet juice and was fearful about getting a haircut from the barber but he could be reassured about this by his mother.

After five months his speech continued to improve still with an Italian accent. He repeated an Italian phrase almost constantly to the family. He grew in height and weight. He frequently dreamed about a dog chasing him. The mother was much less protective of him and allowed him much more freedom.

Two years later he did not remember the tonsil operation. He said he was just a baby. But he recalled vividly a circumcision which he had a year after the T&A. He also had a skull fracture and thereafter was concerned if anyone pulled his hair. Despite these events he was quite mature and masculine.

Severely Disturbed Children

Among the 143 children there were one atypical child and one schizoid adolescent.

Courtney, age six, was an autistic child with arrested development. He spoke hardly at all, was aimless in his activities and unable to make contact with grownups or children. The patient was the only child of an abusive alcoholic father and an infantile mother who was overdependent on her own mother. She had generalized anxiety and some special fears for instance that her house would blow up. She expected T&A to cure the patient's speech. She had prepared him by saying that ether smells like mother's perfume and that he would get ice cream afterward.

Preoperatively he was bewildered, wide-eyed and restless repeating over and over "Mommy gone. Oh. Oh."

Postoperatively he ate nothing for four days but then showed some interest

in a doctor's kit. His mother was disappointed that his speech was not improved. Four weeks later he wandered around more restless than before and his mother now expressed her fear that he was 'crazy' and asked for shock treatment. This behavior continued. Five months postoperatively it was reported that in school he had stopped talking but wrote everything. It would seem that the hospital experience had increased his anxiety and bewilderment. Later he was taken into psychotherapy and is improving slowly.

Sandra, age fourteen, was described as shy, having no friends staying out of school most of last year, fearful and depressed. She had been a feeding problem in early childhood. She had been placed in foster homes several times for long periods because her mother was frequently in psychiatric hospitals, probably for schizophrenia. The father left the family when Sandra was four years old.

On admission the patient seemed suspicious and hostile. She denied fears and told that she had two bones in her throat which would come out. Immediately after the operation she seemed frightened and complained that her throat hurt more than she thought it would.

Six weeks later she complained that her tongue felt funny and that she missed her period. Nine months after the operation she was fearful and seclusive, preoccupied with her nose for which she wanted a plastic operation, feeling that everyone was looking at her.

It is not possible to evaluate whether T&A increased the patient's severe disturbance, but it certainly influenced the content of her delusional ideas in regard to her body image. Tongue and nose became the organs of concern together with upset about menstruation; most likely they were phallic symbols with underlying fantasies about her sex identification.

DISCUSSION

Observations on 143 children undergoing T&A showed that the operation was an important and stressful experience for each child, activating the great childhood fears—of abandonment, of mutilation, and of death, and that it stirred up fantasies of transformation and of getting a baby. Most children were able to integrate the experience as far as we could follow them, but this does not exclude the possibility of a delayed reaction or later reactivation.

Among the children who had undergone an operation prior to T&A were some where the former experience had heightened their apprehension. Others on the contrary seemed able to cope with the later operation better, either because they felt they had mastered it before or because the reality of such an event was not as terrible as their anticipating fantasies. The impact of a former operation depended also on the type of operation, its specific meaning for the child, and other individual factors.

For a number of children the T&A became a constructive experience, either as atonement for guilt feelings or as challenge to their ego strength.

and a gain in prestige. For some, the improvement in general health allowed a greater flow of libido toward other people and activities. In some the attitude of the mother changed and a more positive relationship to the child became possible.

For certain children, however, the operation was a disturbing or disruptive experience. Most of these children had neurotic trends or definite disturbances before T&A, or they had experienced but not integrated frightening life situations (e.g., death of a relative). These children were psychologically vulnerable at the time of the operation, and they were unable to assimilate this threat without serious sequelae. For such children preparation of the conventional kind does little to increase their capacity to withstand such an onslaught. Rather they require working through some of their deeper anxieties. Where there is evidence of a personality disturbance or a history of recent traumatic events in a child's life, careful consideration should be given to his emotional status with the view of postponing the operation or of taking psychotherapeutic measures.

Even with the less disturbed children, preparation involves more than giving accurate information. Where the mother is very anxious about the procedure, as quite a number of our mothers have been, she imparts this anxiety to the small child. In some older ones, it seemed that they could ward off this contamination, or even gain strength by comforting mother. In other cases where the relationship between parent and child was hostile or highly ambivalent, the mother's attempt at preparation seemed to strengthen the notion that the impending procedure meant being sent away or getting punished.

In regard to the hospitalization it seemed important, as stated in the preliminary report (Jessner and Kaplan, 1949) to allow the child to keep a token—a toy, a penny, a picture, etc.—as a tie to home and as a sign of one's own identity, and if possible to allow the child to wear some of his own clothing. The twenty-four hour hospitalization before operation, devised by the Massachusetts Eye and Ear Infirmary, had a reassuring effect on the majority of the children. In most of them we saw the initial anxiety decrease. For some of the children under four years of age, the effect of a waiting period, particularly over night, was dubious.

In a few private cases, the mother stayed with the child. While her presence certainly was a comforting assurance against the fear of abandonment, we saw on the other hand that if the mother was anxious the child felt it. The fact that mother could not prevent 'the needles' and other dreaded manipulations sometimes aroused the child's hostility against his mother, which in turn frightened the child much more than aggressive acts or words against a stranger like the nurse or the doctor.

On the whole it seemed that a mother substitute—which in our study so frequently became the role of the psychiatrist—was a more adequate solution. A nurse might very well substitute for the mother. The child should feel that one nurse in particular was his protector (A. Freud and Burlingham, 1943) although he could share her with other children.

We also saw that acknowledgment of fear and expression of anxiety in play and talk tended to enhance assimilation. We observed suppression, denial, and overcontrol of fear collapse with a bang and we can confirm Ives Hendrick's statement (1949) that lack of anxiety is prognostically a bad sign. Encouraging the child to express his feelings should, however, not be misunderstood as inviting the child to give up control completely. The notion of being able to deal with danger and pain has been one of the most reassuring mechanisms for the children. "To cry like a baby," as one of our little girls said, or not to be a "crybaby," summoned ego strength. Another helpful defense mechanism the children showed us spontaneously was the turning of the passive into an active role, by playing the surgeon or the protecting mother for a doll, a Teddy bear, or a young child. The effectiveness with which the child can use his defenses is influenced by the extent to which the adults comprehend that even such a minor surgical procedure has a great emotional impact.

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MASTURBATION AND DEATH

or

A COMPULSIVE CONFESSION OF MASTURBATION

By MARIE BONAPARTE (Paris)

Felicia, a child of eight or nine, is in the pangs of the struggle against masturbation. She succeeds in suppressing it through fear of death, her nurse having threatened her that if she continued, it would kill her, as in the case of a young man she had known who had died of consumption.

But once the masturbation has been given up, obsessional symptoms arise in the latency period. Felicia is compelled to ask her nurse endless questions in which the word 'button' is always included. For example "Has such and such a lady eight or ten 'buttons' on her coat?" She has to ask such questions over and over again, and is never satisfied with any answer. She reiterates the word 'button' with the utmost anxiety, as if it scorched her lips. But the anxiety would be far worse, more abiding and cruel, if Felicia were to keep these questions to herself. When she has asked them often enough, she feels relieved, for a time, until some new question rises in her mind in which the word 'button' must again be included, and which she must compulsively express to her nurse.

It was found in analysis that the "button" was at first a most fascinating object to Felicia. She had witnessed a primal scene in broad daylight and had displaced the representation of the round glans penis unto the round fly buttons of the man (association by resemblance and contiguity). Then, in masturbation, she had identified her small phallic clitoris with a 'button,' as felt by her small fingers.

Thus, when the temptation to masturbate arose afresh, in the latency period, it awoke the substitutive representation of a 'button' on clothes. As usual, however, it was severed from the original representation of the flesh "button" which it replaced, but acquired the negative anxiety affect now inherent to it. To utter the word 'button' in whatever context was like exhibiting to the forbidding nurse the object of the temptation.

the "button" with which the child formerly masturbated. The word was substituted for the thing.

Asking these compulsive questions was, on the exhibitionistic level, a confession, but a defiant one as well as one that implored absolution.

The nurse used to laugh at such compulsive utterances, and would answer: "What does it matter how many buttons there are on the coat of Mrs. X. or Miss Y.?" And sometimes she would say the right number if she happened to know. Whatever the answer, Felicia experienced it as a reassurance. For it was more than an answer to the harmless manifest question: it was experienced as an answer to the latent question: "Does it matter if I masturbate? Do you allow it? Will I be absolved from the death penalty?" And Felicia would then feel secure in life, relatively secure! Until a new temptation and a new question would arise to torment her anew.

At that time Felicia also suffered from a phobia of poisons and the child had to be reassured constantly. She used to ask her nurse: Do you think I may have swallowed this or that poison? The nurse laughed and the laugh and denial which accompanied it signified the asked-for reassurance, the denial of the penalty attached to the wishes at the root of the poison phobia: erotic wishes regarding the father involving pregnancy by him followed by death. The mother of Felicia had died at childbirth, which was an illustration to the infantile mind of the reality dangers of sexuality.

The poison fear remained on the phobic avoidance level: a wish transformed into a phobia, the positive sign having turned into its opposite, the negative sign — instead of +.

The phobic obsessional symptom of the "button" had undergone the following development:

(1) The wish for the "button" of the man viewed in early infancy, then for the girl's own phallic "button" in infantile masturbation;

(2) The phobia of the "button" but transferred from the flesh buttons to the clothes buttons, because playing with such buttons brought about danger of death;

(3) Lastly return of the repressed. Under the instinctual stress, the wish for the "button" returns and is defiantly expressed to the forbidding person. But at the same time the girl implores her pardon which is expected from the answer, thus escaping the danger of death by her absolution.

The primal equivalence of the "button" with the glans penis is further confirmed by a curious obsessional representation which a few years later imposed itself on Felicia. Having once glanced at a man who greatly intrigued her by looking like an old faun, she imagined he had small

mother-of-pearl buttons sewed on the pupils of his blue eyes, a representation which filled her with disgust for some days. (Eyes=penis=button.)

Some of the secondary transformation of the wish for the "button" into its phobic counterpart lingered in a certain dislike of Felicia's for clothes with buttons displayed on them. Especially if they were round and shiny, with holes in them (square and elongated ones and buttons covered with material were hardly objected to). What Felicia disliked most were buttons on double-breasted coats. Probably because they seemed to proclaim that instead of the unique and eminent "button" possessed by men, women were reduced to the humble clitoris and to the double "buttons" of the breasts.

A word more may be added to this observation:

It is known that the fear of physical harm and death as punishment for masturbation can follow a double trend: either the "sinner" may suffer or die himself for indulging in his sin, or in doing so he may bring harm or death to others.

Felicia belonged to a rather narcissistic type and in consequence related the punishment first and foremost to herself: she herself would die through it!

But something of the altruistic fear for others always remains mingled with narcissistic fear for the self, as it also does, in the opposite case. Thus Felicia, when she confessed masturbation to her nurse and begged absolution from her, doubtless had an unconscious impression that such absolution would also benefit her nurse whom she loved as well as she feared her.

A CRITICAL NEUROSIS IN A TWO-AND-A-HALF-YEAR-OLD GIRL

By SELMA FRAIBERG (Detroit)

I

Sally was two years old at the time of the outbreak of a serious anxiety state and sleep disturbance. Shortly after the child returned from a visit to the home of her grandparents in another city she appeared tense and strangely quiet. At night she awakened screaming after an hour or two of sleep and could not be induced to go back to sleep. For almost the entire night she would sit rigid and watchful in her mother's arms or in a chair. She complained that *de noises bodder me* and her mother thought that she was disturbed by street noises or the sounds made by people in neighboring apartments. During the day the slightest noises produced a startle reaction and sometimes she would scream in terror. Often without any seeming provocation the child would cry out and clasp her mother almost in a faint. Although she was an exceptionally precocious child with a vocabulary almost on a four year level she could in no way communicate her fears to her parents. As the weeks went by she became more and more preoccupied. She no longer played with the familiar toys but monotonously looked through her story books or begged to have certain favorite stories told her. Barbiturates had no effect. The child became almost entirely sleepless.

Because of Sally's vicious attacks on her three month old brother the mother was convinced that the anxiety was somehow related to sibling rivalry and devoted herself fruitlessly to patiently reassuring the child that she was loved. The disturbance had progressed for a period of four months before advice was sought. The problem had become grave when the mother finally consulted a child analyst who referred her to me.

By the time Sally came for treatment the neurosis had already acquired obsessional features. She no longer awakened in anxiety but left her bed like a sleep-walker sometimes asking for milk which she did not want sometimes repeating a stereotyped phrase *Mama I'm here!* She would wander around dazedly for hours after waking and then exhausted seek out another bed in the house changing beds four or five times in the course of a single night. After leaving each one she would whisper *Noises in de bed!* She preferred to fall asleep at night on a couch in the parents' room but the noises pursued her everywhere.

In her daytime behavior there were indications that she was sometimes completely out of touch with reality. Upon returning home after a walk she would insist confusedly at the door *This is not our house* and refuse to enter. For the most part however the anxiety had become isolated. Sally was vague detached dreaming. She had developed a compulsive violent thumb sucking at

the same time she would rub and massage the area just above the genital region. She had acquired certain rituals. She would go about the house to see that all the faucets were turned off. Frequently she would pick up a certain wastebasket and absently present it to her mother. She would not enter the apartment by the front door, only by the back door. Like an infant Ophelia, she would go about the house monotonously reciting scraps of stories or verse. One poem, called "Windy Nights,"¹ she repeated herself and demanded that her mother read it to her. This poem provided the first important clue in our study of the child.

Windy Nights

Whenever the moon and the stars are set,
 Whenever the wind is high,
 All night long in the dark and wet,
 A man goes riding by.
 Late in the night when the fires are out,
 Why does he gallop and gallop about?

Whenever the trees are crying aloud,
 And ships are tossed at sea,
 By on the highway, low and loud,
 By at the gallop goes he.
 By at the gallop he goes, and then
 By he comes back at the gallop again.

It was this poem and the complaint of "de noises" which caused me to suspect at the beginning that the child had witnessed sexual relations. When I inquired about sleeping arrangements, I learned that Sally had slept in the parents' room until seven weeks and had had her own room since. The mother was certain that during the visit to the grandparents, the child had a room to herself. The mother had remained with her for two weeks and then Sally had stayed on alone for another two weeks. Nevertheless, on my suggestion the mother wrote to inquire whether there had been any "changes in routine" in the eating, play, or sleeping arrangements during the child's two weeks alone with the grandparents. It was in this way that we learned directly that Sally had slept in her grandparents' room because they had thought she would be lonely after her parents left.

II

In reviewing the developmental history of the child with the mother, the following points seemed pertinent: Sally had been breast-fed for six months and was abruptly weaned when the mother's milk dried up. From early infancy a bowel infection had been present which required occasional enemas. Toilet training

¹ From R. L. Stevenson, *A Child's Garden of Verses*.

at about this point the affect became isolated and obsessional features appeared

III

During the early months of treatment Sally presented the picture of a physically ill child. She was pale with dark circles under the eyes, her hair lank and disordered. Her face was solemn and unexpressive, totally unchildlike. The detachment, the vagueness of her manner, the fixed stare indicated that the child had only the faintest contact with reality.

In the first interview at her own home she clung for some time to her mother and only slowly approached me when I showed her the new book which I had brought her and offered to read it to her. Since she had discarded all her toys and had refused for months to play, it was necessary to utilize the still remaining interest in stories to build our relationship. I read several stories to her while she listened absorbed, but she did not speak to me nor answer any questions in connection with the stories.

There was a doll named Betsey in which Sally had shown some desultory interest according to the mother. She did not engage in typical doll play but would thoughtfully study and examine Betsey from time to time. After a time I expressed some interest in the doll and asked Sally whether she would like to bring it to me. Sally brought the doll and stood anxiously on one foot as she pointed to an ink spot on the doll's arm. Who did it? Who did it? she asked rapidly. These were her first words to me. I asked her to tell me. I did it! I did it! I saw that the ink mark could only have been made with a pen, and the thought occurred to me that Sally had tried to give the doll an injection. To my question, Oh, does Betsey go to Dr. Lawrence? she nodded vigorously. When I asked, Does she like to go? Sally answered, No, she doesn't like to go! I said, Oh poor Betsey! Let's tell her that she can have an ice-cream cone after she sees Dr. Lawrence. This was the practice after the visits to the doctor.

In this way we began an absorbing game. We gave the doll ice cream, we took her to Dr. Lawrence. I gave Sally a pencil to give Betsey an injection, which she did with serious attention. Afterward the doll had ice cream again. We played the game over and over. After a while Sally introduced a new factor into the game: she put the pencil into the doll's anus (this was a wetting doll with a hole in the region of the anus) and excitedly pushed it in and out. From time to time Sally would pull out the legs of the doll and look searchingly inside.

At the end of this interview I told Sally and her mother that I knew Sally did not like injections and was afraid to be hurt. I told Sally that her mother and I did not want Sally to be hurt. I learned privately from the mother that the pediatrician understood and regretted the effects of the injections upon the child, but that he felt the course of the injections would have to be carried to its completion: there were to be three more injections.

It was on this day too that the mother told me that she had had a reply to her letter regarding changes of routine during the visit to the grandparents. We learned that Sally had slept in the grandparents' room. Since the mother had

knowledge of psychoanalytic theories I was able to discuss with her the possibility that Sally had observed coitus

Following my first visit Sally had her best night in months. However, the next night was very bad. She wakened screaming several times and could not be induced to return to bed. We recall that this had been the earlier pattern which preceded the isolation of affect. The following day she was aggressive, shrill and noisy, exploding in rage several times. She had begun again to react to the slightest noises with great terror.

I asked the mother to tell Sally in detail what happens at night, that she does these things because she is afraid, and that I would now come to see her every day and could take away her noises.

During the second visit Sally showed me the new doll crib which her aunt had sent to Betsey. The mother explained that during her visit to her grandparents Sally had been fascinated at her aunt's house by a doll crib with bars and had begged to have one just like it. She could not be encouraged to play with me, however, and clung to her mother in great fear.

As before I told stories but she was inattentive. She seemed tense and expectant and I was able to see several times the exaggerated reaction to slight noises. She would tremble violently and cling to her mother in terror.

At last I attempted a story about noises. As in the nursery games I would ask Sally, "Can we hear a car? A car goes who-o-sh. Can we hear a dog? A dog goes arf! arf!" etc. When I came to the wind sounds she withdrew sharply and caught her mother's hand in fear. I had already regretted this much directness when a moment later Sally went over to the doll Betsey who was lying in the new doll bed. She engaged in silent play for several minutes. She picked up the doll, then laid her down. She picked up the doll again and felt the bed by smoothing it with her palm. Over and over she repeated this pantomime each time feeling the bed. After a while I said, "Did Betsey wet her bed?" No answer. Then Betsey was made to stand up in bed. Sally pressed the doll's face between the bars. Then she returned the doll to a sleeping position. This pantomime too was repeated many times.

I: Does Betsey see something?

Sally: She hears a noise.

I: What does she hear?

Without answering she continued the pantomime a while, then took Betsey from the bed and held her.

I: Why does Betsey get out of bed?

Sally: She can't sleep.

I: She wakes up because she hears a noise?

Sally: No. She wakes up, then she won't hear the noise! (She told us in this way that the noises occurred in a traumatic dream.)

I: Betsey can hear. All little girls can hear. Sally can hear."

Sally, smiling and teasing: I can't hear! Then coming closer, beginning a chant: I can hear, I can't hear! She covered her eyes. I can't see. I can see."

I laughed and said Sally was pretending. She was pretending that she can't see and can't hear. But I knew that she could see and could hear.

Sally nodded. *I can see. I can hear.*

Following this interview, the mother reported that when the father came home he asked Sally, "Who was here today?" expecting her to respond with my name. Sally, self-absorbed and musing, replied without thinking, "Grandma and grandpa."

Later in the same day Sally came out of her bath naked, stood before the long hall mirror and studied herself. She then quoted from the poem "My Shadow": "And sometimes he's so little there is nothing there at all."

Meanwhile the nights went from bad to worse. Following this last recorded interview, Sally awakened several times in great terror. She could not fall asleep and begged her mother to sleep with her. Once the mother found Sally crawling on top of her in bed, clutching and embracing her sensually.

In the third interview Sally immediately brought me one of her favorite stories to read. "Wead Fanny Forgot," she ordered. When I had finished, I commented, "Fanny forgot and Sally forgot." She ignored this and brought me another book. "Now Cinder's Secret," she said. This was the story of a cat who one day showed a little boy and girl her "secret," a whole litter of newborn kittens. When I finished I commented, "Cinder has a secret, Sally has a secret." She gave no response. Instead she went to the doll bed and repeated the ritual of putting Betsey to bed. At the point where Sally felt the bed I asked, "Did Betsey wet her bed?"

Sally: "She *can't* wet her bed."

I: "Why?"

Sally: "She *can't*."

Sally began to feed Betsey from the doll's nursing bottle. With evident enjoyment, she watched the water spill on the rug. I said, "Betsey is just a little girl. Sometimes little girls wet their beds. Their mummies do not get angry. Let's pretend. Let's pretend that Betsey wets her bed." Sally immediately responded. Her mother contributed a piece of cloth for a sheet. I began by wetting Betsey's bed, picking up the doll and reassuring her. Next Sally played the game, doing as I had done. Then, at one point Sally took the nipple off the bottle and poured water through the nipple (like a funnel) onto the bed. This delighted her most of all, and she ran first to the bathroom and then the kitchen to fill the bottle with water from the taps. She turned on the faucets full force and left them on. (We must recall that until this point she had maintained her faucet rituals, going about the house to see that they were turned off.) She played the game with the nipple as funnel for a considerable time, pouring water in a stream on the bed. At the end of the hour, as she was still playing her water game, I asked, "But what could happen if Betsey wet her bed?" Sally said, "Spank her." Her mother, overhearing this, shook her head to indicate to me that she had never spanked Sally for wetting the bed. I said to Sally, "But Mummy will not spank her." The mother added her own reassurance. Sally made no reply.

Following this interview the faucet rituals disappeared. They did not return. The mother reported that during the night Sally was restless and wakened twice for long periods. She refused to go to the toilet although she seemed to want to go. Once during a waking period she asked to play the wetting game with the doll. Following this she fell into a relaxed sleep.

In these first three interviews several factors appeared clearly enough to allow some tentative constructions. The ritual play of the doll who peeked out from behind the crib bars, who could not sleep because she heard noises, was Sally's report to us of the repetitive dream which caused her to wake in terror. The fragment in which she felt the bed to see if it was wet probably belonged to the period immediately upon waking, that is, the dreamer is about to urinate when a strong prohibition exerts its influence and interrupts the sleep. The child, awake, feels the bed to reassure herself.

In these early interviews Sally described the events of a night in the room of the grandparents, the details of which will be seen in the later analysis. But already she has told us how she was awakened one night by the noises of the grandparents in coitus. She observed them and experienced an excitement which caused her to wet the bed. At this point she made her presence known to the grandparents, perhaps by calling or crying out, we do not know for certain. The rest of the story is seen through the fate of Betsey, the doll. We recall that she could not wet the bed (paralleled by Sally's own faucet compulsions), and only after our reassurances and the water play did we learn what could happen to Betsey for wetting her bed. 'Get spanked.' The grandparents, angered by the interruption, spanked the child 'for wetting.'

We shall see later that the injections for the staphylococcus infection had an important bearing on the course of the entire neurosis. Even at this point, however, we can see that she had identified the injection with an enema and, we suspect, with the male organ in the penetration of the female.

From the third interview on the therapeutic hours took place at my home. Soon Sally became acquainted with my playroom materials and gave names to the dolls. She took a special fancy to a doll she called Barbara who had a tiny hole (a manufacturing defect) in the genital region. Repeatedly during the hour Sally would bring the doll to me with a monotonous chant, Barbara has a hole Barbara has a hole, Barbara has a hole. When I would begin to discuss it with her she turned away and ignored me. There were rituals of taking off Barbara's pants and putting them on off and on over and over, sometimes for an entire hour. The doll Barbara could enter the house only through the back door.

In addition Sally was fascinated by a haulaway truck, a tractor and trailer

which hitched together and which carried five little cars. She ran them over the floor making noises like a train.

In the meantime she had grown worse at home and now revealed true hallucinations: She heard noises where there were no noises. She spoke of voices, "people talking," when there were no voices. She refused to go to the toilet and remained continent for hours despite her suffering.

In the eighth interview, which followed a completely sleepless night, we began to learn more about "Barbara's hole." After the usual undressing ceremonies and the remarks about the hole, Sally put Barbara to sleep and began to play with the haul-away truck which she called her "twain." Repetitiously she put the little cars in and asked me to take them out. She then "woke up" Barbara and asked me to read *The Noisy Book* (a recent favorite which told the story of a little dog with a bandage on his eyes. "Muffin could not see but he could hear. He could hear everything"). From these cues (putting the doll to sleep, playing out a scene, waking up the doll) I had learned to recognize the "reporting" of a dream. We cannot be certain that the same symbols were used in the dream, but from the play sequence we can infer that she had associated the "twain" (i.e., the two trucks which hitch together) with putting in and taking out little cars and with the noises which Muffin could hear. In other words, the two trucks which hitched represented the couple observed; the act of putting in and taking out the little cars symbolized conception and birth; and the noises, as we know, were the sounds of coitus. Sally had correctly intuited the relationship of coitus to conception.

As I read, Sally interrupted, addressing me earnestly: "Selma, what does Barbara see?"

I (in the style of *The Noisy Book*): "Does she see a chair?"

Sally: "No!"

I: "Does she see a book?"

Sally: "No!"

I: "Does she see a little boy?"

Sally: "No!"

I: "Does she see an auntie?"

Sally: "No!"

I: "Does she see an uncle?"

Sally: "No!"

I: "Does she see a grandpa and a grandma?"

Sally: "Yes, she sees a grandpa!"

I: "And what does the grandpa do?"

Sally: "He will hurt her!" Then switching suddenly she cried, "She sees a man on a twain, a man on a twain, a man on a twain."

I: "Yes, and what else?"

Without answering, Sally ran wildly out of the room; she screamed to her mother, "Mama I'm berel, I'm here."

Her mother reassured her. With difficulty I got her to return to the playroom, but soon she ran out again repeating her cry. This happened four or five times. Feeling the necessity of bandling some of the anxiety at this point, I asked

the mother to come into the playroom, since Sally would not stay with me otherwise

As soon as the mother joined us, Sally resumed her play. She brought Barbara to me and showed me her hole. 'Who did it? Who did it?' she said over and over.

I "Who did it?"

Sally "The man did it with the hatpin!"

Mother "Sally is afraid of hatpins"

Sally "I am scared of hatpins. Dr. Lawrence did it with a hat pin" (i.e., hypodermic needle)

I gave her a pin and asked her to show me. She stuck the pin into the doll's hole.

I "Do you think the man made the hole?"

Sally "Yes, he made the hole"

I assured her that the man did not make the hole. That was the way Barbara was made. She was made just right. Sally was made just right. Sally made no reply.

The mother interrupted at this point to tell me that Sally was afraid of the front door of their apartment. To my question Sally replied "The man will be there! Then suddenly she cried out, 'But I'm hiding! I'm hiding!' We were not able to learn more at this point.

We can now see more clearly how the castration anxiety had been reinforced by the injections which Sally had received. The painful penetration of the needle interpreted as a sadistic act by a man, the doctor, was fused with the image of the grandparents in coitus. 'He will hurt her!' she had said, speaking of the grandfather. Further, she believed that "the hole" was made by the man, that is, that the woman is castrated by the man. The front door, then, can only refer to the vagina. She must avoid the front door because a man will be there and he might come through the front door. To her, this meant castration.

The effects of this interview were felt immediately. Far from bringing about release of tensions, these communications brought on a new and crucial phase of the illness. Now the child withdrew from reality with an alarming completeness. During this period, an entire week, she again looked like the little sleep-walker we had seen at the beginning. But now there seemed to be a total involvement which had not been evident in the earlier days. The mouth and jaw were relaxed, the eyes were dull and staring. She spoke very little and when she did speak, her voice was noticeably flat and without affect. There was a stiltedness about her and a trance-like quality in movement. She sometimes repeated phrases over and over, tonelessly. Barbara has a hole, Barbara has a hole, has a hole, has a hole. Barbara has a question, Barbara has a question. "When I would ask, 'What is her question?' she would answer, 'Barbara has a hole, has a hole, has a hole.' I would repeat my reassurances about Barbara's hole. She gave no evidence of hearing me but would pursue the eternal phrase.

For a while she avoided the beloved haul away truck. If I drew her attention to it she would regard it unseeingly then move away. Her favorite 'Noisy' book was avoided in the same fashion. In fact, her lack of reaction to all auditory stimuli was striking. Even the common house or street noises which she had always remarked upon had no effect on her. Sudden noises, the doorbell and telephone, the abrupt hissing of the radiator which had always startled her, caused no reaction. My own voice did not seem to reach her. There was no response at all.

The wastebasket ritual was renewed. Dozens of times she would bring the wastebasket to me in silence. I would ask, 'What did you find in the wastebasket?' There was no answer. I would pretend to look for something in the wastebasket. She would watch me dully and in silence. Only once did I catch a clue. There was a sequence in which she followed the wastebasket ritual with a question about the fire engine, 'What color is it, what color is it?' She knew her colors well and knew the color red. This question and other fleeting impressions suggested to me that she might once have found a sanitary napkin in the wastebasket. I asked the mother about this. She remembered with surprise that several months ago, following the birth of the baby brother, Sally had found a used napkin in the wastebasket and had brought it to her. Her mother had explained to Sally that this was what happened to grown up ladies and that when Sally grew up she would have this too.

Although I now knew for certain the meaning of the wastebasket ritual, the information was of no use at this point. When I would speak of finding something red in the wastebasket, Sally would treat this with the same blankness which was her response to anything else at this time. It was impossible to communicate with her in any way.

Several times in the course of the interview she appeared to be struck by some thought. She would then get up, unfasten the door and walk quickly to the waiting room, calling tonelessly, 'Mama, I'm here. Mama, I'm here.' She once happened upon a picture of a train and immediately began her, 'Mama I'm here!' repeating the phrase over and over to her mother.

It seemed to me that the words, 'Mama I'm here' could only make sense if we regarded them as a reversal of the unspoken thought, 'I am not here,' alluding to feelings of unreality. In this deeply regressed stage, the child's seeking of the mother was an attempt to restore the sense of reality. From the train incident we might venture the hypothesis that each time the repressed material broke through into consciousness it was met by a denial on the part of the ego, a denial of such overwhelming strength that it swept with it the reality sense. Our knowledge of the discovery of the sanitary napkin is of further use, since we must conclude that the child interpreted the bloody napkin as evidence of the castration of her mother, our material on her observation of the grandparents gives concrete evidence of her belief that the grandmother was castrated in the sexual act. Moreover, Sally must deny what she had seen and heard in

the grandparents' room because to admit the reality of her observations mean to admit the reality of castration. This explains why the interview in which the primal scene material made its first direct appearance ended in an abrupt breaking off the communication at the point, "the grandpa will hurt her," to be followed by the most extreme withdrawal from reality.

Now Sally had become completely inaccessible to treatment. She was almost oblivious to my presence, and all my efforts to reach her failed. It was certain that if the child continued in this pattern we would see a complete disintegration of the ego. The therapeutic problem daily became more grave. Sometimes I would hold Sally on my lap and tell her reassuring stories, repeating again and again that I would not let anyone hurt her. At such times she would lie quite still and very close to me, but in no way did she indicate that she heard what I said, nor did she react to it. I was certain that she would be unable to bring out any material by herself at this time. Her infantile ego could not deal with the material in any way, and we could expect only further removal from reality. Yet, if I were actively to bring out this material I had to risk traumatizing her further and completing the withdrawal. By the end of this week the reports from home and my own observations did not permit any other therapeutic choice. The withdrawal had reached an alarming point. It seemed necessary to risk an active technique.

In our fifteenth interview Sally reiterated her ritualistic phrases and repeated her ritual acts with the wastebasket and the cars, leaving them abruptly to call, "Mama, I'm here." When she returned from her mother I held her on my lap for a while and told her a story about Sally who was a little girl who had a secret which made her afraid, promising her, as usual, that if she told me her secret I would fix it so that she wouldn't be afraid. But she made no answer. After a little while she slipped off my lap and went to the cars. This ritual would have been followed a moment later by her automatic cry, "Mama, I'm here!" but this time I broke into the play immediately. I pointed to one of the cars, the tractor, and said, reversing the obvious symbol, "I think this is a grandma car." She immediately protested, "No, *this* is a grandpa car!" Apologizing for this "mistake," I asked her to show me the grandma car. She picked up the trailer truck. "Like *this*!" she explained and hitched them together. Then she made her train noises. I said, "The grandpa car and the grandma car make a lot of noise." She broke into an unexpected giggle. Then I joined her in a game with "the twain" and made train noises. To my astonishment she joined in the game with me. I made up a song about a grandpa car and a grandma car who made a lot of noise and she joined me in singing this too. The balance of the hour was spent in tireless repetition of the game and the song. There was good contact with me now. Sally was active, sometimes smiling, and even a little aggressive in her playful banging of the door.

When we joined her mother, Sally became quieter, then suddenly ran to hide behind the door. Her mother asked her if she were playing 'secret.' Sally giggled a little and came out announcing to her mother that she had banged on the door. She left apparently in good spirits.

An hour after her departure the mother called me, greatly disturbed. Sally had begun to scream in genuine terror at the door of the apartment. She clutched her mother tightly, crying, "*Mama, dis is not our house. Mama I'm not me!*" Her mother was unable to comfort her. She was carried screaming into the house. For over an hour the screaming continued. At last she fell into a stuporous sleep. Sally slept for over five hours. The mother reported that she had wakened refreshed and cheerful. Shortly afterward she went into the living room and brought her mother the wastebasket. Her mother asked her what she had found. Sally said, 'A cloth! A purple. No, a wedl' (red). The mother told her that she should tell me about it tomorrow. Later, while sitting on the toilet, Sally said reflectively, "I will tell Selma about de cloth tomorrow."

Actually it was two days before she told me about the sanitary napkin.

IV

Following this critical day we began to see a new phase of the neurosis. Sally became mischievous, boisterous, and defiant. She refused to go to the toilet, deliberately urinated on her mother's lap, on the floor, and by standing on the toilet seat. She wet her bed nightly. In play she was destructive, taking great pleasure in breaking furniture in the doll house which she would bring to me in mock grief. She broke the doll house piano legs, the floor lamp of the doll house, always with a mischievous smile and a great show of self reproach.

In the first interview after the critical day just described, Sally was in high spirits. Running joyfully into the playroom, she picked up the two hitching trucks, singing out that the grandpa car and the grandma car made lots of noise. At one point in the interview she brought the tractor and trailer to me. Pointing to the coupling on the tractor, she asked, 'What's dis?' I explained that that was so the truck could fit into the other truck, and she latched the two cars together. She brought the doll Barbara to me, commenting, 'Barbara has a hole.' Next she brought the boy doll Jimmy, saying, 'Barbara has a hole. Dat's how she's made!' (a parody of me). Then picking up Jimmy, she continued, 'And Jimmy's made so's he can fit de hole like dis!' As she put the two dolls together, she broke into a wicked but delighted laugh.

A little while later she put Barbara in one bed and Jimmy in the other. She turned Barbara's bed over. 'Barbara fall!' she explained. "And den she soaks her bed. She soaks her bed!" I said, 'I know. Barbara doesn't *really* fall. She sees pictures in her sleep and she *thinks* she falls and then she soaks her bed. Is that right?' 'Yes,' Sally said and laughed delightedly. "Den Barbara soaks her bed. Peter [her brother] soaks his bed.' She picked up the boy doll and scolded him in her mother's words: "Too big for dat. Too big for dat! (Her mother had scolded her for deliberately urinating on the floor and the toilet seat.) I said, "Now I know why Barbara wets her bed. Maybe she thinks she is Jimmy or

Peter Maybe she thinks that if she were a little boy then she could wet all over She thinks she could stand up and wet on the toilet and stand up and wet on the sofa and in her bed Is that right? Sally Dat's just what she finks! And she laughed in delighted squeals

Following this interview she announced to her mother that she wanted to use my toilet We were interested because Sally had not asked to go to the toilet for weeks earlier on this day she had refused when her mother suggested it.

In the next interview Sally reported that Barbara had a question Why won't Barbara go to the toilet? At my suggestion that we find out Sally stood the doll on the toilet seat I said that maybe Barbara would like to make weewee the way boys do Sally said I fink so When I stood up Jimmy the doll Sally said Jimmy makes weewee standing up I said yes a little boy has a penis She made Barbara sit down then she inspected the boy doll

Sally He's a boy but he doesn't have a penis

I explained that they didn't make him properly A real boy has a penis of course

Sally Peter has a penis

I Yes does Barbara?

Sally No

I Does Mama?

Sally No

I Does Sally?

Sally No

I Does Daddy?

Sally in a loud voice NO!

I Are you sure?

Sally Yes Putting Jimmy in the truck and making loud truck noises He hurt his penis Now he has a hole!

I How did he hurt his penis?

Sally ignored me Then Put a piece of paper in his hole He put a piece of paper in his hole She picked up a piece of red cardboard which had interested her before In the wastebasket! she explained earnestly and emphatically The one with the flower on it! (at home)

I Did Sally find something in the wastebasket?

Sally A cloth!

I What color was it Sally?

Sally It was wed! (red)

I And did Sally think that Mama was hurt?

Sally NO! Daddy Daddy was hurt!

Then began a nonsense word sequence ending with what sounded to me like It was black. I said Sally is fooling me Sally looked at me candidly No You're fooling me! she said (Afterward I realized that she must have said blood not black) I reassured Sally again and again that neither her daddy nor her mother was hurt but she appeared unconvinced I asked her if we should tell Mama about the wastebasket, and she agreed To her mother I explained

that Sally had found something in the wastebasket. Sally added "A wed cloth I explained that Sally thought someone was hurt. Sally said earnestly, 'Daddy Daddy was hurt! Her mother said, 'No, dear, Daddy was not hurt,' but Sally made no response.

In these interviews we observe an alteration in the child's behavior accompanied by a new version of castration. We see how she identifies her self with a little boy in the act of urination. In the play sequence where the doll does not like to go to the toilet, Sally finally sits the doll down to show me, and then searches in the toilet for something lost. This suggests, of course, Sally's belief that a penis could disappear like a stool in the toilet. If she did not sit down on the toilet, if she could stand up like a boy to urinate, then the tragedy would never have occurred. In identifying herself with little boys she also denies her own lack of a penis, she can do what the boys do. Of the greatest importance, however, is the belief that the father had been castrated, that the bloody napkin signified 'He hurt his penis. Now he has a hole.' She denied that the mother was hurt. We suspect that with the admission to consciousness of her own destructive wishes toward the penis, she has attributed to her mother the castration of the father. There is a further suggestion that in her child's logic the castration of the male was understandable revenge on the part of the female for her own castration in the sexual act.

Once again we encountered a therapeutic problem. With an older child the incident of the sanitary napkin would be clarified by an explanation of menstruation. With this two-and-a-half year-old there was clearly no way in which menstruation could be interpreted without adding to the traumatic weight of the experience. If we explain, as her mother did, that this happens to grown up ladies, we have confirmed her belief that this is a form of castration, since there is no way in which we could have explained the menstrual cycle to her. Associating the bleeding with conception or birth would support the infantile theory of birth as castration. In the absence of any means of dealing rationally with the problem with the small child we could utilize only techniques of reassurance and abreactive play.

In the interviews that followed we played the wastebasket game over and over. Each time I assured Sally that neither Daddy nor Mama was hurt. These games and the reassurances were woven into interviews for weeks, until the incident had diminished in importance and receded into the background. We cannot, however, give full credit to the cathartic value of play here, since we shall see that, as more and more material was explored in relation to the castration fantasies, the event of the sanitary napkin took on more real proportions.

For several interviews Sally introduced a new feature into her play. She would bring the two dolls, Barbara and Jimmy, to me, ask me to examine them with a toy stethoscope. Then she did a parody of our interviews. She interviewed the two dolls, addressing particularly Barbara. Barbara has a question: What is your question, Barbara? She can't tell. She can't tell. Is Barbara afraid? Yes, Barbara is afraid. She can't tell. I asked who had told her not to tell, and she replied: De boy. De boy did. Bad girl! [spanking Barbara] Stick her in the suitcase. Lock her up [acting this out with a small suitcase]. Oh good morning, Barbara! [an unmistakable parody of my voice]. Did you have a good sleep? Sally took off the doll's dress and pants. This interested me, because the mother had told me of the great fuss Sally had made during the past few days, refusing to allow her mother to take off her pants. Sally coaxed the doll very nicely, like a patient mother. See, Now we take it off like this. Now we take it off like this. At this point I said: Who took Barbara's pants off? Sally: The boy did it. Bad girl, Barbara. Bad girl! She jabbered in a parody of another voice which I could not identify.

In the next interview she was occupied with a game in which she stabbed at clay with an orange stick. Suddenly she spoke up: Dr. Lawrence's needle broke. The nipple came off! (This was later confirmed by the mother: once during an injection just before I started to see her, the needle had broken as it penetrated the skin.) For several minutes Sally pushed the orange stick in and out of the holes rhythmically, then she broke off the stick deliberately. Now she said: Now there's a little piece inside Barbara. Get Barbara. Barbara has a hole! [hesitantly] I have a hole [turning to Barbara]. Did you put something in your hole, Barbara? To my direct question of *who*, Sally replied: I did. I put my finger in my hole and it makes me happy. I assured her it was all right to do this. She made no comment but returned to her play, jabbing viciously at the clay. It hurts when he puts it in. When I asked what hurt, Sally answered: The needle.

In later discussion with the mother I learned that this week Sally had resumed masturbation after months of abstinence.

The next few nights were very bad. She awakened several times screaming wildly and as usual refused to go back to sleep. In interviews she was destructive with play equipment and tried to ignore me. She protested against coming to see me. Then in the interview which followed our last report, Sally followed such a destructive orgy with a solemn and quiet drama with the dolls. Like a solicitous mother she put Barbara to sleep. She said goodnight and kissed her. Barbara gets up. She is not Barbara, she is a boy. No, Barbara, you must go back to bed. [Tucks her in] Barbara is running. She is running down the stairs. Why is she running, Selmama? (her term of endearment for me.)

I: I think she is afraid. Is she running away from somebody?

Sally: She is running away from Selma. And she wants to run and she doesn't want to.

I: Barbara is afraid that I will find out her secret. She wants to tell and she is afraid to tell.

Sally: "Yes, Barbara has a secret. Oh, now she falls down. She falls down!"
I: "Why does she fall?"

Sally: "Because she ate the cookie. She falls down and she wakes up!"

In this way Sally communicated a dream, from the reluctant going to sleep to the waking up after the fall.

She resumed her play. Sally: "Where is the boy. Can he sit on the toilet? No, he can't. He stands up. Barbara can stand up." She had her stand up to urinate in the toilet. She took off Barbara's pants, put them on, took them off again. Then she brought the doll to me. "Zamine her." After I had done so, I said, "I wonder if the children like to play doctor?"

Sally. "Yes Judy and Timmy play doctor." (These are story book children) Then she added carefully, "And Danny. Danny plays doctor." (This was the first time she had ever mentioned the companion of her visit to the grandparents) She was silent, then she cried out, "She didn't want the cookie. But she *did* want the cookie!" I was reassuring. She continued. "Here Barbara I'll give you a cookie!" She put a "pretend" cookie in the doll's hand, and took down the doll's pants. Next she put the doll in the doll house. "She's hiding. She's hiding. And no one can see her. Why is she hiding, Selma?" I said that I thought she had a secret and she was afraid her mama would be angry. But her mama would not be angry.

She played with the two hitching cars for a little while. She showed me how they hitch. She said. "The big truck fits the little truck. And she heard the noise." I asked who made the noise. "It was a man." Here she trailed off and switched to other play.

When it was time to leave, we joined her mother. Sally watched her mother as she picked up her purse. Suddenly Sally cried out. "Mama, Danny took my little purse! But I didn't like it, Mama. Oh, Mama, I *didn't* like it. He took my purse." Sally climbed upon her mother's lap. I explained that Sally had been afraid that her mother would be angry, but her mother was not angry. Her mother knew that children liked to play doctor. Sally continued earnestly. "I was angry. I said no. Then I slammed the door. I slammed the door. I slammed the door."

In the following interview we learned more about Sally and Danny. She played with the boy doll and the girl doll. She addressed the girl doll. "It's lovely. You'll like it." She took the doll's panties down. To the little boy. "O K. little boy, off your pants will go! And he gives her a cookie." Silence. 'She made a point with a pencil and it broke inside Selma zamine her' I examined the doll and assured Sally the doll was fine. Then I asked, "Does she think that she has something inside? Does she think something broke like Dr. Lawrence's needle?' When Sally affirmed this, I assured her this wasn't so. Then I asked if someone had put something in the doll's hole.

Sally: "Yes, I did it."

I "Did Sally put her finger there?"

Sally mocked me. "Did Sally put her finger there?" Then suddenly, "Peter has a penis."

I Yes all little boys do

Sally Barbara has to go wee wee She put the doll on the toilet then looked inside

I What is she looking for

Sally She lost it in the toilet.

I What did she lose?

Sally (emphatically) Her penis

I Did Barbara think she had a penis once and lost it?

Sally regarded me puzzled No you took it You took the penis away Mama took it. Here of course I reassured her once again and repeated the explanation of the differences between boys and girls She was obviously unconvinced

In the following hour Sally began once more by acting out the drama of the little girl and the little boy As before the little boy gave the little girl a cookie. At the end Sally announced triumphantly And she bwoke the cookie! Immediately afterward she brought the boy and girl dolls to me for examination I assured her again that each was quite all right She put Barbara to sleep and brought out the grandma car and the grandpa car She made her characteristic noises for the twain then stopped and said Barbara has a question I said

I think she wants to know what they are doing Sally nodded Using two dolls I explained I told her that the grandma and the grandpa loved each other very much and when grownups love each other this is what they do I suggested we pretend that the two dolls were a man and a lady I showed her how the penis could fit right inside the lady demonstrating with the dolls. They fit! Sally repeated I said yes and that they liked it they loved each other and it was very nice and beautiful

Sally was reflective Then she pointed to the male doll His penis is bwoke Who bwoke it Selma? I bwoke it! I said that Sally thought a penis could be broken when a man and lady love each other She thought that Dannys penis was hurt. But it was not really I went over the story of how little girls and little boys were made how men and women were made She was dubious

The mother reported to me that on the day following this interview Sally made up a poem while sitting on the toilet Sally said Of genitals it is beautiful of genitals it is fun She seemed to be pondering this problem all day because several times she picked up her favorite doll and said sadly Minette bwoke herself!

In our interview she told me this too I suggested that Minette thought that if she touched herself down there she could break herself But this was not so Sally as usual was not convinced Following this explanation she brought me a picture book a Polish folk tale called Grandpa and the Turnip In the pictures Grandpa tried unsuccessfully to pull up the big turnip Grandma helped him and so did numerous other friends and animals. In the end the giant turnip was uprooted and the whole line of tugging assistants fell with a plop. "See!" she announced The grandma took it! Now I tried another approach. I told her a story about a little girl When the little girl first saw her little brother she could not understand why he had something she did not have. So she thought she

could take it from him. But of course she knew she could not. Then she thought maybe this was what a grandma did. But it was not really so. One cannot take a penis away. It is not like a turnip. She made no comment, except that later with her dolls she said reflectively upon examination, 'She thinks she has a penis, but it isn't weally so.'

That night she had an exceptionally bad time of it. She was up for five hours, complaining of noises. The following morning she was very hostile toward her mother. In the midst of a tirade against the mother Sally said, 'You have a penis. You hid it inside. You thought you would hide it so I wouldn't know. But I do know! I think that's clever of me to find out! With this ringing accusation Sally marched out of the room. Her mother made vain explanations.

In her interview that day Sally arrived screaming and protesting and refused at first to come into the house. Once inside she screamed for several minutes, then went into a profound sulk. She refused to come into the playroom at first but lay on the floor of the waiting room sucking her thumb and throwing disdainful looks at me.

I was certain that this hostility was caused by my interpretations in the last interview, that one could not obtain a penis by taking one away (her theory of the grandmother and mother). Recognizing this I tried to keep up a running stream of comment directed toward easing her narcissistic injury. I remarked on her prettiness and how glad her mother and I were that she was a girl. I talked about the differences between boys and girls, commented that when a boy grew up he could not have a baby grow inside *him*, but a little girl could. How a little girl was made just like her mummy, etc. She was completely unmoved, though obviously listening.

At one point Sally entreated her mother to come on the floor with her. Her mother refused. Then Sally, with unexpected strength, tugged at her mother, upset the mother's balance so that she fell sprawling on the floor. Instantly Sally jumped on top of her mother and sat astride her. Her mother firmly removed her, and Sally reverted to screaming once again.

Finally I resorted to sitting on the floor across from her, sucked my thumb, kicked at imaginary objects and in every way behaved like a naughty little girl. She was intrigued and I identified myself as a story book character called Roxanna Pretends and told a long involved story about the things I liked to pretend. Sometimes I liked to pretend I was a car, or a boy, or a baby. I went on to say that at night I heard noises and could not sleep but it was fun. If I were to tell Selma then I would not have to be afraid anymore. But why should I tell? I'd rather be afraid. It's fun to be afraid. This irony was not lost on Sally. A moment later when I got up and announced that I was glad we had so much fun today but that it was time to go home, Sally sprang to her feet and made a dash for the playroom. She ran to get her special toys, crying greetings to them. She wanted very much to please me. As if she wanted to show me how well she had learned, she explained. The grandpa car and the grandma car go choo-choo. They love each other. That's right? I said that was right. She showed me pictures of a boy and girl playing together. "They like to play," she said. They

like to play doctor" I assured her all children do. She laughed in a relaxed way. She left reluctantly.

Nevertheless it was difficult to interpret to her why she was angry at me, and the ambivalence toward me continued in the interim. I learned through her mother that she was not endorsing me as a therapist, these days. On the morning of her next hour, she addressed her dolls on the subject of my professional competence. She ended by wagging a finger at her clown doll with the ringing admonition, "Boy, don't go see Selma! Don't go, boy!"

She had also been very upset because she had found a drawer full of broken pipes which belonged to her father. She brought the pieces to him crying, "Bwoke! Bwoke!" He said he knew it and didn't care. Later in play, she said aloud, in a wondering voice, "He knows they're bwoke, and he doesn't care."

In the next interview we went through the usual ceremonies of examining the dolls, while I gave reassurance. Then Sally, examining one of the dolls, said meditatively, "She does have a little piece down there. I realized at last why she was so insistent that her mother and I had 'a little piece.' This must be the clitoris. I said that of course girls and ladies have a little skin down there. It is not a piece of a penis (her own interpretation) but a little skin which belongs to them. They are made like that. She accepted this without comment. I believe now that her faith in me had been badly shaken when I had explained to her repeatedly that ladies and girls do not have, as she said, 'pieces of penis.' It was necessary to clarify the misconception regarding the clitoris. It is interesting to note that the mother reported a vast improvement in behavior following this interview. We even noted with encouragement that she said to her mother later that day, 'When I grow up I will have hair on my genitals and hair here [under arm] like you.'

Today and for several weeks following, she took a fancy to two new poems.

The Little Elfman

I met a little Elfman once,
Down where the lilies blow,
I asked him why he was so small
And why he didn't grow.

He slightly frowned and with his eye
He looked me through and through
'I'm quite as big for me,' said he,
"As you are big for you."

The Little Dreamer

A little boy sat dreaming
Upon his mother's lap
That the pins fell out of all the stars
And fell into his cap!

So when his dream was over,
 What should the little boy do?
 Why he went and looked inside his cap
 And found it wasn't true.

In Sally's absorption in the first poem we can see her attempts to reconcile herself to what she feels to be inferior equipment: "I'm quite as big for me as you are big for you." In childhood the little elf is a familiar symbol for the genital organs. In the second poem "the pins fell out of all the stars and fell into his cap," which we might take to be a representation of castration. The boy awakened "and found it wasn't true."

In the following interview, Sally became interested in a new game. While she was examining the boy doll, I remarked that really this boy doll was not made right. He should, of course, have a penis. I asked her if we should make him one. She agreed, and we made one out of clay. Sally announced that she wanted one for Sheila, another doll. I said that we could make her one but she'd look awfully silly with one because girls don't *really*, we know. Sally giggled, "She'll look awfully silly!" but nevertheless wanted her to have one. Next she insisted on one for "Geraldine" and "Barbara," all this with much giggling.

She abandoned this play after a while and had me read "Babar." She pointed to the baby elephants and said, "Babar has babies." Then, pointing to the doll, "And Barbara has a baby?" I appeared puzzled and asked where. "In here," she said pointing to the belly of the doll. I remarked that Barbara would *like* to have a baby, but that she didn't *really*, when she gets big like her mama she will *certainly* have a baby. Sally made no comment but began an exploration of all my desk drawers. "What's this?" she would ask innocently about an object that she could easily identify. I would tell her. "What's this? What's that?" After playing this game for a while, I suggested that maybe that wasn't what she wanted to know at all. I thought that she wanted to know something about me. Did she wonder if I had a baby inside. When Sally nodded, I explained I did not, and that I was sorry because it would be very nice to have a little girl, just like Sally. Someone who was made just right, like Sally. With this Sally spontaneously rubbed her face against me and smiled.

At home she told her mother, "Wouldn't I look silly with a penis. Mama?" Her mother agreed, telling her how glad they were she was a girl.

We had the feeling these days that things were going along nicely. Her behavior was much improved; the nights were very little disturbed in comparison with the early days. She seemed to be seeking identification with her mother. She looked healthier, happier. But even in this quiescent period we saw small signs of what later developed into a new phase of the neurosis. She would react to small noises, as she had earlier. "What that noise, Selma?" tugging anxiously at my skirt. "Hear that, Selma?" I would strain my attention to identify the

noise. Sometimes I thought it was the radiator or an airplane, and would ask her if this was what she meant. She would never identify the noise for me. But several times I had the distinct impression that she was not reacting to an external stimulus. There had been no audible noise. Her mother reported the same observation to me.

"I'm afraid of noises," she told me earnestly one day. I asked, "Do you think noises will hurt you?" No answer. She turned to the cars. "Hello grandma car. Hello grandpa car. Go choo-choo-choo." I commented on this by reminding her how she had once wakened and seen grandpa and grandma. She had heard them make noises and thought they were hurting each other. But they were not.

Sally turned to a music stand in the room, asking as she had many times before to whom it belonged. I told her again that it was my husband's. Sally, suddenly: "I have a husband!" "You do? What's his name?" I asked. Sally began playing, "Oh, I think his name is typewriter. No I think his name is desk. I think it's music stand." I laughed at her joke and assured her that when she grew up, she would surely have a husband.

At the end of this interview an unexpected element was unearthed. Sally didn't want to leave today. She hid from her mother in the living room, finally coming out reluctantly to have her outdoor clothes put on. While sitting on her mother's lap, she said thoughtfully: "*And grandma said, 'Do you think she saw anything?' and he said, 'No she couldn't see!'*" Sally looked up at me. I said, "But that's a joke because Sally really did see, didn't you?" Sally: "I did see. And I *heard* the noise." I assured her that I knew that. There was nothing wrong with that, nothing at all.

In view of the quantity of material here, it might be well for us to summarize some of our findings at this point. It is useful for us to study the two phases of the neurosis which unfolded during the first month. In the first phase, we recall that she was passive, overwhelmed and helpless in the face of omnipresent danger. In the second phase, the original sadistic components re-entered consciousness, and we observe how all the earlier material is reshaped by the child in terms of the tendencies of which she is now aware. The phobic content becomes clear to us when we are able to analyze the destructive fantasies which emerged later in treatment, and which preceded the phobia historically.

We are able to see how, during the passive phase, her observations of coitus brought forth the conviction that the female was castrated in the sexual act. "He will hurt her!" she had explained. Later she had equated the penetration of the penis with the painful injections. We have reason to believe, further, that the discovery of the sanitary napkin confirmed her belief that her mother had been castrated. (We had a different version later, of course.) At other times, she expressed her belief that she had made her "hole" by inserting her finger, i.e., that she had lost her penis through masturbation. In still another version, she had lost her

penis in the toilet and blamed her mother for taking it away, equating penis and stool. In all of these versions, the little girl or the woman is the passive victim of a sadistic act.

But then we are interested to see how, in the second phase, many of these theories are reversed. Now it is the male genital which suffers castration. "He [the male doll] hurt his penis. Now he has a hole." When she returned to the wastebasket theme she insisted that Daddy was hurt. And she drew new conclusions from the simile of Dr. Lawrence's needle. Did not Dr. Lawrence's needle break off once? And did not a little piece of the needle stay inside? Her mama, I, Sally, all of us have "little pieces inside—a piece of a penis." She supported her theory through her knowledge of the clitoris, "a little piece." We learned of the episode of Danny. He had stolen her "little purse." And she was very angry (indeed!) "He broke his cookie!" She sought further proof for her theory of the sadistic act of the female. She showed me the picture of "Grandpa and the Turnip" and insisted, "The grandma took it!" She pointed to the broken pipes of her father. "He knows they're broken and he doesn't care."

All of these later theories achieved their potency, we must conclude, from the sadistic fantasies which had preceded the outbreak of the neurosis. In the neurosis, the sadistic wishes were turned back upon the ego and the evil designs were now perceived as threats directed toward the ego from an objective source. This is the classical phobic picture.

It was suggested earlier that the neurosis acquired obsessional features at the time that the injections for the staphylococcus infection were resumed, in the period just prior to the beginning of treatment. It is apparent that the injections reinforced the castration fear—made it real—and that the ego was forced to adopt new measures in the face of such danger. We then perceived isolation of affect, undoing rituals, and other stratagems of the ego to ward off both the objective danger and the instinctual dangers. The loss of the reality sense should come in for fuller treatment based on later material, but we already have clinical evidence that the sensations of unreality occurred at such times as the repressed material surrounding the observations of coitus attempted to break through into consciousness. ("Mama, I'm here!")

To return now to the onset of the phobia. We know that prior to the visit to the grandparents, Sally had been outspoken in her envy of the little brother's penis. She had acquired small comfort from her mother's assurances regarding the advantages of being a girl. We can conclude from the later material that she was already preoccupied with theories about how she could obtain a penis, that she had destructive fantasies toward her little brother, and that she blamed her mother for her loss. Of the sex play with Danny we do not have a complete picture. We do

not know why she avoided Danny unless some previous adult admonition had interrupted their play. We do know from the material that there had been sex play and that when Sally's mother, encountering the children struggling together, had felt that Sally was trying to get out of his embrace, she had said, "Danny, Sally doesn't like that." Sally's own interpretation of these words have been encountered in treatment "Mama, Danny stole my little purse. And Mama I *didn't* like it!" In obedience to the mother's words, Sally had to deny that she had liked the experience.

We notice the way in which she utilized the words of the adult in this instance and in another. She told us, "And the grandfather says, 'No, she couldn't see.'" She utilized these words as a literal command, later reinforcing her own denial of what she had seen and heard.

We now have a sequence of events leading up to the point of the outbreak of the phobia—envy of the little brother, destructive fantasies in relation to him and the wish to obtain a penis, discovery of the napkin, sex play with Danny and the warning of the mother, the observation of coitus between the grandparents. We have reason to assume that until the observation of the grandparents, Sally's preoccupation with sexual differences had led her to familiar conclusions, i.e., her mother had not given her a penis, also, her mother had taken her penis away. Her destructive fantasies in relation to the little brother's penis and Danny's penis also aroused in her the belief that she might have lost her penis through castration, in a reversal of the wish. It remained for her observations in the grandparents' room to confirm these infantile theories. We have seen how she projected upon the couple both the passive and active castration fantasies which were her own at the time. The signs of a struggle, the noises, were evidence to her that castration was a reality. It was this perception which contributed the exciting cause for the phobia.

VI

After the first month there was a brief quiescent period. As mentioned earlier, the symptoms had diminished markedly in intensity. Nights had improved, reality contact was evident, and there appeared to be some beginning efforts on the child's part to come to terms with her grief over the lack of a penis.

These encouraging signs were short lived. One day the mother cut her finger. It was a shallow cut, and the mother wore a band aid for a few days. This produced a serious setback for Sally. She referred again and again to the mother's finger. Her mother tried to convince her that the finger was not badly hurt and offered to demonstrate, but Sally refused to accept any explanations. The wastebasket ritual was renewed in interviews. I assured her again and again that her mother's finger was all there and that it *did not hurt*. After many days she finally accepted these assurances.

We had seen even earlier, however, that Sally's hallucinated noises were beginning to make an occasional reappearance. In a rapid development, the auditory hallucinations began to dominate the scene. Dozens of times in the course of a single hour, she would cry out, 'What's that noise?' and hide in terror behind a chair. There was apparently no external stimulus. She could in no way communicate the nature of these noises, and it was difficult at first to find a sequence in the material which could provide clues. Reports from home suggested one possibility, her old anxieties in relation to the sounds of the vacuum cleaner. The mother reported that Sally would scream in terror for long periods even if she heard a vacuum in other parts of the building.

In an interview with me one day, she set one of the little dolls on the toy toilet, then cried out in terror, 'What's dat noise?' This was the first confirmation of our hunch. What I asked her if she thought it was a toilet, she gave signs of acknowledgment. She then told me that the doll 'lost her clay' in the toilet. She was referring to a clay penis which we had once put on the doll. I told her that maybe she thought this was like a B M, but it wasn't really so. One did not lose a penis in the toilet. She was unconvinced.

Her nights became worse. The terrible screams were repeated once again. And again there was the pitiful shifting of beds all night long in order to get away from 'de noises'. She refused to go to the toilet, remaining continent for seventeen or eighteen hours. When the mother felt her suffering was acute and finally placed her on the toilet, she screamed and turned white with fear until she urinated.

The mother tried vainly to cope with both the hallucinations and the anxiety reactions to actual noises in the house. Once the mother reported that she had tried to reassure Sally while she was screaming at the sound of a distant vacuum cleaner. She suggested that they could go look at a vacuum cleaner and see that it could not hurt one. Sally stopped her screaming for only a moment.

'Take Peter to see the vacuum cleaner!' she suggested and resumed her screams.

At the same time she became extremely aggressive toward her little brother. She maliciously snatched things away from him, teased him, ridiculed him, bullied him, and enjoyed throwing him down. In one interview she pointed to the boy doll's penis and said craftily, 'Barbara will eat it. She will eat it.' I assured her that Barbara could not get a penis that way. With this she went into a sulk and accused me, as she used to, of having a little piece of penis inside me.

In interviews she often liked to act out a story we knew of a rabbit who read a book which he didn't like and threw it to the floor. She would march up and down announcing in her shrillest voice, 'He throws de book on de floor! He throws de book on de floor!' Sometimes she would threaten to poke in the windows of the doll house or break up the furniture. Once I said, 'And Sally gets very angry too, sometimes.' Sally replied, 'Yes, I do. I get angry at Peter!' Confidentially, 'He took away my purse!' I told her that she thought Peter took things away from her, but he didn't really. When I began to speak of the advantages of being a girl, she put her hands over her ears and shut me out.

For a while she refused even to use the word "penis" which had always been part of her vocabulary and would refer to the doll's clay penis as "his clay" or

"her clay." About the same time she began to put the clay on the girl doll's behinds, announcing proudly, "That's *her* clay." Once she put this "clay" in the toy toilet and asked me to flush it. I took the clay out of the toilet. At just this point Sally began to scream, "What's dat noise?" There was no noise, of course. I took the opportunity to discuss with her the fact that she was afraid to see her B.M. go away. I gave reassurances and put the doll on the toilet several times, each time showing Sally how there was a new B.M. Later she asked me to put the boy doll on the toilet. We did so, and arranged for him to have a B.M. too. As if confused, Sally put the girl doll back on the toilet and threw the doll's clay penis in. I then explained that a boy makes a B.M. and a girl makes a B.M. But a B.M. is not a penis. Several times in the days following she would instruct herself or the dolls, "But a B.M. is not a penis!"

Nevertheless the hallucinated noises continued. One of our difficulties lay in the fact that it was difficult to interpret to the child that her noises were hallucinated. In one interview she was engaged in a type of play typical for this period. She manufactured clay penises for all the girl dolls. After pasting each one on she would giggle and, borrowing my words, would say, "There! Doesn't she look silly!" In the midst of this play, she cried out that she heard a noise. Again I engaged in fruitless effort to get her to tell me about the noise. I suggested the toilet, the vacuum cleaner. She denied each one vehemently. I was certain she was deceiving me. Then she said, "Barbara bears a noise." I said, "Barbara does, But Geraldine does not hear a noise. Linda does not bear a noise. Selma does not. Mama does not. But Sally hears a noise. Sally bears noises but no one else hears them!" Sally listened with intelligent absorption. "Well, then," she said, "I must be very silly!" She was quite struck with this insight. Later, at home, her mother overheard her addressing her dolls: "She didn't wealize that she heard the noises only she didn't weally hear the noises."

Even this much insight brought about significant improvement for a short period. She began to sleep through the night, and even on those nights in which she awakened there was only brief waking without much anxiety. During this quiescent period, she brought forth an additional piece of information. At home and in the interview, she spoke of her stool as her baby. This was clarified for her in an interpretation.

VII

Shortly afterward we began to encounter a new group of theories. We have already seen how Sally's theories regarding her wish for a penis had met frustration through interpretation. My assurances to her that there were advantages in being a girl, that one day she too could have a baby grow in her tummy, that she would grow up just like her mother, all met with indifference on her part. We must agree with Helene Deutsch (1945) that the promise of a baby to the little girl requires a postponement of the wish which cannot be understood. Deutsch points out that

the child relinquishes her penis envy chiefly through identification with the mother.

We might review some of these theories as we encountered them in the months of treatment that followed:

Sally became fascinated with a story called "Someday," which has to do with the wishes of a little boy. "Someday" he will be an ice cream man. "Someday" he will be a fireman, and so on. She liked particularly the picture on the first page, a little boy and a little girl eating ice-cream cones. "Look," she said. "He has one and she has one!" Then she urged me to put the little boy's clay penis in the mouth of Geraldine the doll. I did not, but asked: "What will she do?"

Sally: "She will swallow it."

I: "And then what?"

Sally, quoting smugly: "Someday she'll be an ice-cream man!"

I: "Does she think it will grow, and some day she will have one?"

Sally: "That's what she thinks!"

Again I repeated the worn interpretations and the reassurances about little girls. Insistently Sally opened the story book, pointing to the two children eating ice-cream cones: "He has one. She has one." I said again, "Yes, a boy can have an ice cream cone. A girl can have an ice-cream cone. But an ice-cream cone is not a penis." She ignored me completely and pursued her play in which the little girl takes the clay penis in the mouth, always with the triumphant, "Now she will swallow it."

During this period her violence toward her little brother, Peter, was renewed with such strength that the baby was in tears and terrified all day. I was genuinely afraid that she might seriously hurt the child, and the destructive effect upon his own developing ego had to be taken into strict consideration in treatment. Sally was permitted a considerable amount of destructive play in hours with me, with the explanation that she could hurt the dollies and she could be angry here but that she could not hurt Peter. It was necessary to permit such small amounts of gratification in the interviews, always, however, accompanied by interpretations at strategic points to prevent serious acting out at home. We were relieved to find that she could accept this, diminishing her attacks on her brother.

We had periods of apparent improvement. For a time she began to give the little boy doll a penis, albeit with the sardonic statement, "He looks silly, too." I began to take advantage of this; thereafter, when she would encourage me to "put clay on Barbara," I would often refuse casually by saying that I loved her better as a girl. She accepted this sourly. Thus on one occasion, when she urged me to give Barbara a penis, I repeated that she would only look silly, that I liked her better as a girl; Sally finally grew quite cross with me. That afternoon her mother reported that she went around the house singing a parody of "Foggy Dew." "And the only only thing that I did dat was wong [wrong] was to go to Selma's house."

Nevertheless, there was general improvement during this period. For a

while Sally herself stopped putting penises on the girl dolls. I was feeling encouraged. One day she studied all the dolls. She announced, "Geraldine does not have a penis."

I: "That's right. She's made just like a girl. And we love her."

Sally: "And Barbara does not have a penis."

I: "That's right. She's just right!"

Sally, with a sly smile: "But *I* have a penis."

I tried another approach one day. I had discovered a story called "Gwendolyn, the Goose." It was the story of a little goose who was very sad because she wanted to be a gander. Her brothers had so much more fun! Her mother became quite cross with her because she didn't act as a little goose should. At the end of the story, Gwendolyn meets a fine young gander called George; they build a nest; and on the last page we see Gwendolyn sitting smugly on top of a large heap of eggs.

Sally greeted the story with indifference. She liked only the first part. On the following day, her mother called me in alarm. Sally had developed a new symptom. All day she had been going about the house screaming, "I don't want an egg! I don't want an egg!" Her mother reported that she had assured Sally she didn't have to eat an egg, nevertheless, Sally acted as if someone were forcing her to do so. I enlightened the mother as to the meaning of this "symptom" and tacitly admitted defeat once more.

She read "Babar." Sally: "A boy does not eat peanuts. An elephant eats peanuts!" (Note pun.) She pointed to the elephant, Babar.

I: "Oh, do you think that's how the elephant got his trunk?"

Sally, shrewdly: "That's what I think!" She quoted from the "Rain Story." "Rain will make the corn grow high! Rain will make the flowers grow. Someday I'll be an ice-cream man!"

Along with this material, it was noticeable that Sally had transitory returns of her "noises" and would not permit herself masturbation. The vacuum-cleaner phobia returned with renewed strength at one point during this period. I assured her again and again that the "sweeper," as she called it, could not take anything away from Sally. We achieved our best results, however, through a game. On one occasion I suggested that I would pretend to be "a sweeper" and Sally could be one, too. We both crawled under a table. I said, "Hello Sweeper!" and Sally replied: "I'm not a sweeper. I'm a mee-per and you're a Sel-meeper!" We both laughed at her joke, and in this way the game of Meeper and Sel-meeper was born, a game which afforded her considerable gratification and some degree of control of the danger.

A further clue to the nature of the transitory hallucinations was secured near the end of this period. As mentioned previously, Sally no longer permitted herself to masturbate. I began to notice that she was developing a compulsive type of lip biting, tearing the skin off her lips. At first she would not let me talk about this. Finally, through the use of a doll, I suggested that the doll would like to put her hand "down there," but since she is afraid, she does things with her mouth instead. Sally instantly explained: "*If she puts her hand down there, she will hear the noises!*" I said yes, that she thinks she will hurt herself, and

then maybe she thinks that the noises will hurt her. But that was not so. She would not hurt herself. She can put her hand down there. With this, Sally began to laugh with relief. Following this interview she permitted herself to masturbate and once again we began to see signs of improvement. Yet it is noteworthy that the prohibition returned again in a very short time, although for some what different reasons.

Sally had told us that if she touched herself "down there," she would hear a noise. The nature of this noise opens up a fascinating field for exploration, but for the moment let us take just one feature of the noise. Throughout the record, the noises represent danger and are associated, via the primal scene observations, with castration. Sally was afraid, then, of her noises, of castration, when she indulged the wish to masturbate. It was this objective danger which exerted its inhibiting influence on the wish.

The character of this noise may be suggested by the remarks of Freud (1915) in 'A Case of Paranoia Running Counter to the Psychoanalytical Theory of the Disease.' Here a detail in the case of a paranoid woman presents a striking parallel to our case. The woman patient had gone to the rooms of her lover in the daytime. In the midst of an embrace, the woman had become frightened by a noise, a kind of knock or tick. Her friend thought that perhaps she was referring to a clock in the room. The woman, however, became convinced that her lover had engaged a photographer to take pictures of them secretly while they were making love. The subsequent litigation brought the woman to Freud for consultation. Freud deduced that the ticking or knocking noises could be doubted on a reality basis, that the woman had become aware of sensations of throbbing in the clitoris, and that "this was what she subsequently projected as a perception of an external object." Freud gave further evidence for this hypothesis from the analysis of such a 'knocking' dream in another woman patient.

In the case of Sally, we can suspect that the same mechanism has been at work through the objectification of genital sensations, with the added feature that she must fear the noise because of the association of noises with the observation of the grandparents and with the idea of castration.

Very shortly in the history we will encounter another example of the way in which the child renounced masturbation on the basis of still another objective danger.

VIII

In the progress of Sally's treatment we encountered a new and interesting phase of the neurosis. We recall that she had already brought forth her theory

that a little girl could obtain a penis through biting off and swallowing the member of a boy. These notions, like the others, had been discouraged by me and interpreted over a period of several weeks. In each instance, the wish was frustrated.

During the height of these aggressive oral fantasies Sally actually attempted to bite her little brother's penis. She was sternly warned by her mother when this was discovered. Now we began to see a new group of symptoms appear.

There was a refusal to eat for almost a two-week period. With the encouragement and coaxing of her mother she ate enough for sustenance but avoided food for the most part and nibbled apathetically at anything put before her. There were episodes of forced vomiting. But the most striking feature of this phase was the refusal to talk, a factor which greatly handicapped the course of treatment during these crucial weeks. For the most part she was silent, though often she would engage in a variety of gibberish which was baby talk, yet something more developed, an intelligent child's parody of baby talk. She would pretend not to know the names for the simplest and commonest objects.

At the same time her aggressions against the baby brother took the form of refined cruelty. Her mother had warned the baby not to touch the exposed electric wall outlet. Sally would say in a parody of her mother, 'Oh Peter, don't touch it. Don't touch it. Peter watch out. You're near it! You're near it!' (At such times the usually silent Sally could become quite verbal.) The baby would weep at this constant stream of admonitions and the mother would warn Sally. With a great show of obedience Sally would say, 'Peter, you're not near the switch, you're not near it, dear!' She would repeat this spurious reassurance until the child would burst into tears at his new torments.

Her violent, compulsive thumb sucking had returned, and she had once again renounced masturbation. I was certain that this new sadistic period was the outcome not only of the suppressed oral aggressions but also the renunciation, once more, of genital pleasures. Each time I observed the compulsive thumb sucking I assured Sally that it was all right to touch herself 'down there' that she didn't have to suck her thumb this way. My encouragement made no difference to her. I asked her mother to reassure her about masturbation. But even with this Sally was unconvinced. She would only smile slyly and continue with her thumb-sucking.

It was this sly, cunning, knowing smile which puzzled me, in addition to everything else. My impression—which I could not quite justify—was that she mistrusted our words of reassurance. It was as if she felt we were trying to trap her and that she was telling us she was too smart for that.

The renunciation of genital pleasure was complete. For a time I could in no way account for the source of the prohibition, then gradually I acquired some insight into this curious mechanism. Sally was fascinated by the wall socket in the playroom. She would point to it repeatedly uttering some gibberish (which I could not understand) and which she quite evidently did not want me to understand. I tried every means to get her to talk to me about it, or to trick her into telling me about it. Knowing the story of the wall plug at home, I introduced some possibilities. I suggested that Peter liked to touch the wall plug

She giggled in response. I told her that she could touch my wall plug if she wanted to. She withdrew sharply, hands behind her back. 'You do it!' she said. When I touched the plug, she regarded me in astonishment. I brought each of the dolls to the wall plug and let them touch it. We played this game for several days. One day she herself gingerly leaned forward and touched the wall plug. I assured her that she could touch it and that it would not hurt her, but that sometimes it did hurt a little so that a baby might be frightened. That was why mommy did not want Peter to touch it. Sally began to delight in touching the wall plug. I made the further interpretation that she was afraid to touch the wall plug just as she was afraid to touch herself down between the legs. But that she knew now this would not hurt her. I asked the mother to make the same explanation at home. Sally resumed her masturbation and lost interest in the wall plug, which relieved us all.

Now we can understand how the prohibition was exerted. She believed that if Peter were to touch the wall plug, he would be castrated. (This was, of course, why she herself urged him not to do this in such a way that he would be encouraged to do it.) She took the mother's prohibition against touching the wall plug on the same terms as a prohibition against masturbation. We recall how our earlier words of permission to masturbate were spurned. She thought then that we wanted her to masturbate, to touch her genitals in order to be castrated *in the same way* that she wanted her brother to touch the wall plug so that he would be castrated. She had projected her wishes onto her mother and me.

Following a period of symptomatic relief, which lasted for almost three weeks, we again encountered a brief regressive period. At times she enjoyed baby talk and loved to repeat over and over like a precocious infant, 'What dat?' 'What dat?' The mother remembered that this was exactly the way Sally had reacted when the mother had been pregnant with Peter. She would touch the mother's abdomen and ask repeatedly, 'What dat? What dat?' She knew, of course, about the pregnancy.

During the same period, Sally acquired a fetish. She carried a nested group of measuring cups with her wherever she went. While in the dime store one day, she had suddenly insisted on having the set of cups. Her mother recalled that during an early trip to visit the grandparents—when Sally was just fifteen months old—she had been given measuring cups to play with in the car. Through the fetish and in the 'What dat?' game she was unquestionably re-enacting something from the period of the mother's pregnancy.

In addition to these other symptoms Sally one day defecated in the bath tub. When her mother asked, 'Sally, where do we make B M's?' Sally, quite unabashed, answered, 'Oh, in the toilet—or in bed!' The mother recalled that there had been such a soiling incident in the bath

tub much earlier. She was not certain of the date but thought it had followed the birth of Peter.

In interviews, some of this material appeared and was handled. The 'What dat' game was interpreted on the basis of her curiosity about babies. Once again she advanced her conviction that the baby came from the anus, but when the correct explanation was repeated, she was unconvinced. Later, when we would talk about the origins of babies, she told me that the baby came "*from hisself, from here*" (pointing to the anus). I was not convinced that I had heard correctly, but when I encountered this same insistent explanation from Sally again and again, I understood that she was telling me her theory that one could *give birth to himself* through the anus. She was preoccupied with philosophical problems. She would point to the blank end pages of books. 'What dat?' "It's a blank space. It's a nothing." "But what is nothing?"

Finally, at the end of the month, this phase disappeared as strangely as it had come on. Very little had been handled therapeutically.

IX

For a six week period Sally was symptom free. The sleep disturbance had practically disappeared. Occasionally she would wake briefly, ask for milk, and go back to sleep. There were marked changes in personality and in physical appearance. She looked relaxed, there was color in her cheeks, her eyes were bright. In many ways she was spontaneous and gay. She loved creating messes in the playroom and once daringly wrote on the walls. She told me a story which continued for several interviews of a boy 'who made it in his bed' and giggled as if this were a dirty joke. I allowed her to play the story out with the doll, using plastilene.

It was a quiet, unevenful period.

Then, in a single day, the entire picture changed. Again Sally defecated in the bath tub. It was done in a mischievous and defiant spirit, and she was giggling and impudent when her mother discovered it. Her mother—who had been under a considerable strain that day because of a death in the family—lost her temper at this point, spanked Sally, and sent her to her room. Sally screamed and cried for hours. When her mother tried later to reassure her, it was to no avail, Sally went into a depression which lasted several days. She asked for constant reassurances of her mother's love.

When I saw her alter this episode, I was amazed by the change. Once again there was the sad, old lady face. She looked dull and apathetic. In the playroom she refused to talk or to play with any of the toys. I discussed with her directly what I knew of the soiling incident and told her how sorry her mother was that she had been cross, reassuring her that it was not a very bad thing to do. I arranged for the mother to join us later and to give some kind of apology to Sally. This she did, and when Sally felt the sincerity of her mother's words she

relaxed a little and smiled. Her mother kissed her. When the mother had finished and gone away, Sally and I played out the incident with dolls. Each time the doll "made clay" in the bath tub, I gave Sally verbal reassurances.

All of this afforded only slight relief. Sally's anxiety about defecation now came to the surface. She retained her stools even under great discomfort and pain. She would cry out, wanting to go to the toilet and protesting against it at the same time. Sally's mother gave her reassurances, even told her at my suggestion that she could defecate in her pants. She refused, though once or twice she slightly soiled her pants and watched her mother's reaction carefully.

The night waking returned and with it an obsession about lights. She walked absently about her house commenting in a sing-song voice about certain lamps, "The light is off. The light is off." It was a continuous complaint.

She had known for a long time that the light in my hall closet did not work. Beyond a question some months ago, she had shown little interest in this trivial fact. But now it became a serious issue. She constantly dragged me to the hall closet to point out "The light is off. The light is off." This went on for days. I told her that I would try to have it fixed, and in the interim between appointments tried new bulbs in the socket without success.

The light obsession eluded me. Could something happen if the lights were off? Was this a fragment attached to some earlier trauma? The observations of the grandparents perhaps? Or still earlier? There was no help from Sally. She only repeated her eternal complaint in the dull, monotonous voice.

One day as she was leaving the interview, she led me to the closet with her customary, "It's off. It's off. The light is off." I made my usual banal reply that I would try to have it fixed. "Fix it! Fix it!" she pleaded. I tried to explain that I hadn't been able to, then, in an attempt to show her my good will but utter helplessness, I went into the closet, pulled the light cord without success, and jiggled it for a few seconds. To my astonishment, the light flickered, steadied, and stayed on! Sally let out a little cry of astonishment and awe. "What did you say to it?" she said breathlessly. I lost no time in capitalizing on my divine gifts in this department and told her that I knew how to fix up lights and she probably knew, too, that I was able to fix up children's troubles.

In the next interview, the meaning of the obsession was revealed. There was a strengthened attachment to me at this time, heightened perhaps by my miracle of the clothes closet. In the playroom the subject of the lights came up when Sally noticed the darkened study across the hall and insisted that I go in to turn on all the lights. She led me to the study, and we went around together turning on the lamps. Then, very seriously, Sally said, "My light is off! My light is off!"

Now we could understand. We recall the earlier preoccupation with the electric wall plug and its genital symbolism for her. In her imagery, the light produced by contact of a plug and switch must represent genital sensations. (In this symbol, "light" would be equated with "fire.") Her "light" was off, then. Was it that she could not touch her genitals to

produce light? Or was it that she had touched her genitals but could produce no sensations?

I think it was more likely the latter for if a touch prohibition were involved, it would have been manifest in some way in the ceremonial. There is strong evidence that she had lost her pleasure in masturbation that she could evoke no sensations and was suffering a kind of temporary anesthesia. Hence the complaint. The light is off! When we tie up this symptom with the fear of defecation and soiling the meaning is clear.

Back in the playroom I discussed this with her telling her that I thought she was afraid when she touched herself down there because she thought she might have a B M in her panties. I assured her that this was all right that her mommy would not be angry. It was all right to touch herself and all right if she had a B M. She listened earnestly to this but still seemed afraid. She tested me by pointing to her scribbling on the walls which I had permitted her long ago.

Dose are marks dat Sally made on de wall! I agreed and reminded her that I had not been angry.

It was necessary to make these interpretations repeatedly but after this interview Sally found relief. There followed several days of soiling in her pants at first with great anxiety and apprehension. Her mother handled this with understanding and Sally was at last convinced that her mother would not punish her for soiling. The night waking stopped again and she achieved a great deal of the relaxation and brightness which we had observed in the symptom free period preceding this unfortunate phase. Within a few days after this interpretation and the soiling episodes she told me in a momentous announcement. My light is on again!

From this material we are able to see how pleasure in masturbation had to be renounced along with pleasure in soiling. There were dangers in experiencing excitations in the genitals because of the possibility of discharge of excitement through soiling.

X

The material which has been presented in detail thus far covers the first ten months of Sally's treatment. During this period almost everything that we were to know of the structure and dynamics of this early neurosis had come to light. Only one new and unexpected detail was uncovered in the second year of treatment a factor of the greatest importance in the etiology of the neurosis. This last detail I have reserved for discussion in the next section of this paper.

We may be justified in choosing the first year of treatment for our analysis in these pages because it was this period in which the major part of the analytic work took place, with corresponding relief of the

most critical symptoms. In the three and a half years which have followed, the therapeutic emphasis has been on strengthening the ego and guiding the child through the difficult years of the oedipal phase. She was seen once or twice a week in the period that followed, often on an irregular basis, depending on the need.

I will try to describe the later developments briefly:

By the end of the first year the compulsive rituals, the hallucinated noises, and the distinctive features of the phobic picture had disappeared. The sleep disturbance was almost completely analyzed, it returned only on a transitory basis and with little intensity during the second year. Indeed it had largely changed its character. When the anxious waking ended, a kind of "nuisance waking" appeared for a short period. Sally would waken at night, apparently without anxiety, and would make loud, giggling speeches and manufacture noises until her mother appeared. As soon as the mother implored silence, Sally would invent new noises and giggle with cheerful impudence. She wanted to go into her parents' bed. When this was refused, she found a diabolical joy in keeping her mother awake. The implications are obvious. In other cases of sleep disturbance, I have observed a similar pattern. After the anxiety basis of the sleep disturbance is analyzed, the gain in waking, the disturbance of the parents, or the wish to go into the parents' bed may still have to be reckoned with. Occasionally during the second year of treatment, Sally awakened after an anxiety dream and had to be comforted, but already such waking had come into the realm of normal or typical behavior for her age.

In other ways, too, we saw significant changes in Sally. With the removal of the symptoms, there was a long period in the second year when aggression, defiance, and tom boy behavior created almost as many problems at home as the old neurosis had. Sally's mother showed good tolerance for normal aggression and mischief, but we were often called upon to keep Sally's behavior within limits. Thus, the little girl who had once gone about the house like a sleep-walker, turning off faucets, now, at four years of age, found among her chief amusements turning on faucets—flooding basement, bathroom, kitchen, with joyful unconcern. On some occasions the mother was certain Sally deliberately wet her bed after waking up, and a few times deliberately urinated on the floor. In these ways and many others, Sally gave her mother a difficult time for a while.

There was a tonsillectomy at the age of four which Sally managed with no return of the old symptoms. This was an especially trying period in the hospital, for a nurse had found Sally masturbating in bed and made "shaming" remarks to her in the presence of the mother. Sally was frightened, but with reassurances from her mother and me, this, too, was managed without serious consequences.

The oedipal strivings which made their appearance in the second year of treatment were not disturbed by analytic interpretation except when anxieties arose which required my help. The emergence of the oedipus complex was a favorable therapeutic sign and, so far as possible, we permitted it to take its course without interference from the therapeutic side.

There were continued manifestations of penis envy during that year—outspoken criticism and aggression against the little brother attempts to urinate like a little boy and a long period of preoccupation with minor cuts and scratches and play with band aids which testified to her still active concern that being a girl she had been damaged. There were occasional episodes of sex play with little boys but these brought about no return of the old fears and we could regard her behavior and her reactions as normal for the age.

In the second year of treatment Sally then three and a half entered nursery school. From the beginning she formed strong attachments to her teachers and maintained a positive attitude toward school throughout. But her relations with the other children followed an uneven development. There were periods when she made good forward strides in her group adjustment but these alternated with periods of diminished activity and marked preference for the company of the adults. At times she expressed to me her resentment of the other children candidly admitting that she wanted her teachers for herself. During these same intervals of little socialization at school the mother reported that Sally played contentedly with neighborhood friends which seemed to indicate that when no adult was present she was able to relate to other children.

As we see the developmental problems of the second and third years of treatment imposed different therapeutic requirements. There was little to analyze in the strict sense of the term. The ego of this small child maintained a precarious balance in relation to instinctual strivings for a long period. There was often a see-sawing of affective states—periods of aggression and provocative behavior alternating with phases of withdrawal and preoccupation with her own fantasies. The aggressive content of these fantasies could be easily discerned by watching her face or following her play during the interviews. Our work consisted largely of nursing along the ego permitting a certain amount of gratification of the instincts within the limits of reality and gradually increasing our demands upon the ego in terms of appropriate behavior for her age.

This process was necessarily very slow. Each step forward in independence and social growth required a long period for the consolidation of gains. Typically, in nursery school when Sally had achieved one level of performance or had acquired certain elementary skills, she seemed to have little desire for mastery and moving on to new levels. The director of the nursery school brought my attention to an interesting pattern of growth. It was observed in school that before Sally took each major step forward in the acquisition of new skills or new relationships, she would regress for a while to thumb-sucking and withdrawal or to infantile behavior and speech.

Even allowing a wide latitude for the rate of growth in a child who had once been so severely ill, we felt in Sally an absence of striving, or

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Even allowing a wide latitude for the rate of growth in a child who had once been so severely ill, we felt in Sally an absence of striving, or

a holding back, so that often our active help was required and we had to offer incentives for growth and new skills, with much praise and encouragement. It was as if Sally had to hold onto the ground which she had won so painfully, as if she must hold back as long as possible before risking steps into unknown territory.

When Sally was five years and six months old, she fell ill with poliomyelitis. She was hospitalized for four months. She recovered with some paralysis of the left leg, but the prognosis for eventual recovery is good. She was able to cooperate with the painful physiotherapy and to adjust to the separation from her family during hospitalization. Her mother became pregnant again during Sally's hospitalization, and a new baby brother was born six months after Sally returned home.

In spite of these critical events, there was no return of the old symptoms, which relieved us greatly. It is interesting, however, that for a brief period after the birth of the new brother, Sally developed a transitory eye tic. This disappeared a while later without any specific treatment. Sally was outspoken in her regret that the new baby was a boy, she finally adopted an attitude toward the baby which is the present one, a mixture of maternal solicitude, subtle aggression, and teasing tactics.

On the other hand, we observe that certain character traits have been strengthened by the illness and the prolonged physiotherapy (part of which must be administered by the mother). There is a heightened narcissism, a demandingness—a use of her affliction for gain whenever it is opportune. She sometimes resorts to infantile displays of aggression (crayoning the walls of her home or cutting up quantities of paper). She is often preoccupied with her own fantasies. Naturally, under the exceptional and painful circumstances of the past year, we have chosen to be as lenient as possible in our demands.

Other developments are more favorable. There is a desire for parental approval with a responsiveness and evident warmth toward both parents. She shows considerable pleasure in school and in her kindergarten achievements (She is a year behind in school because of her illness.) Her drawings are lively and skillful for her age. She now takes pride in accomplishment, where once she was hesitant and unwilling to try new things or carry out ideas.

There is still an attachment to me, and we visit occasionally at my office or my home. Some months ago, in a reminiscent mood, Sally recalled in great detail when she first knew me. She described the house I lived in when she first came to me (She was two and a half when we started treatment, three and a half when I moved from this house.) I was astonished at her memory for details of room arrangements, toys—little things which I, myself, had forgotten. Then I asked Sally if she remembered why she used to come to see me. Sally became thoughtful and frowned. I don't remember. I think I did something bad once—a long time ago—but I can't remember what it was."

XI

Perhaps this case report should properly end with the account of an event which brought forth a last and vital detail for the understanding of Sally's neurosis. This material came to me as a kind of belated postscript to the analysis, many months after I had considered that we had learned all the important facts about the dynamics of the neurosis.

First I must refer back to material which I reported in the first months of analysis. Early in the treatment I had found it difficult to cast off the impression that there had been a seduction of some sort—a sexual experience with a man. We recall the ritual of Sally's refusal to enter the front door and her terrified complaint: "The man will be there!" We recall her statements regarding holes (vagina): "The man did it with a hatpin!" "Dr. Lawrence did it with a hatpin!"

I had not known what to do with this impression, nor could I trust my inexperienced judgment. We recall that in the early days of psychoanalysis such recollections of seductions led to mistaken conclusions. I finally dismissed the idea since it was not really necessary to speculate on this unlikely possibility in order to interpret the material. The fantasy could be adequately explained in terms of the sex play with Danny and the injections by the physician during the period of the staphylococcus infection.

One day near the end of the twentieth month of treatment Sally's hour with me was scheduled for a time immediately following a routine visit to the pediatrician's office. Sally was long past the period in her illness when she had been terrified of doctors and needles. She had like any other child seen Dr. Lawrence when she had colds, sore throats, and the usual childhood illnesses. All of these visits with the doctor had been uneventful.

But on this day when Sally arrived for her hour with me I heard her screams from far off. She was carried into the house by her mother. I was alarmed when I saw her for we had seen nothing like this for over a year. She was crying fitfully and as in the early days of treatment her expression looked sick. Between outbursts the detached, absent, trance-like look was on her face.

The mother talked with me alone and told me what had happened. The pediatrician had given Sally a thorough examination. When he started to examine the genitalia Sally began her screaming and he had to stop. I asked the mother if such examinations had been a practice during Sally's visits to the doctor. The mother said that there had been no examinations of the genitalia for quite a long time since there had been no general physical examinations. With the mother's help I tried to determine when Sally might have had an earlier examination of the genitalia. The mother told me that when Sally was

under two and was still taken to the pediatrician for regular "check ups," an examination of the genitalia had been a routine practice at the physician's office!

Now we can understand how the details of a genital examination and the consequent stimulation and the injections by the same doctor cooperated as factors in the fantasy of the man at the front door who made the hole (vagina) with a hatpin!

This more recent event at the pediatrician's office made it possible to work through with Sally some of the earlier material, which had been incompletely analyzed without this information. We had no repetition of these examinations, and there was no repetition of an anxiety attack of this nature.

XII

In the analyses of adults and of children, the effect of the observation of coitus on the mental life of the child is frequently brought to light through fantasies and dreams. In the published observations or case reports of analysts we are reminded again and again that such an observation is not, *in itself*, responsible for bringing forth a neurosis. In the case of this very young child, there is abundant confirmation for this view.

I will briefly cite a few cases from the literature. In Freud's (1918) famous case, 'From the History of an Infantile Neurosis,' the patient's early observation of a coitus between the parents did not fully exert its influence until a later period in the child's development. The significance of the observation, which could not be grasped by the child of one and a half, was only understood at the age of four when the early impressions of this scene served a childhood phobia. Analysis of the phobia and the repetitive wolf dream revealed the child's longings to be copulated with by the father in place of the mother (as in the early scene), but the child was forced to abandon this wish with the realization that the condition for gratification of these sexual longings was castration—to be like mother. In the interim between one and a half and four, there had been a scene of sexual excitement with a servant who threatened him with castration, there had also been sex play with the older sister and castration threats by the nurse when she found him masturbating.

In a fragmentary analysis reported by Abraham (1913), a nine year old girl developed night terrors following observation of parental intercourse. The child had always slept in the parents' room. It was learned that she had been recently engaged in mutual masturbation with a little girl friend. Abraham stressed that it was probably the excitement of these

sexual practices which caused the child to react violently to the incident in the parents' room. He further stated, "I am inclined to think that an investigation would have shown that the recent experience from which she was suffering had received its most important reinforcement from her unconscious, i.e., from repressed memories of a like nature belonging to the first period of childhood." Since the case was not investigated analytically, this could not be confirmed.

Jenny Waelder Hall's 'Analysis of a Case of Night Terror' (1946) reveals, in the case of a seven year old boy, the sadistic conception of intercourse (he, too, had slept in the parents' room), and again it is noteworthy that these observations obtained their importance only after the boy himself engaged in forbidden pleasures, and was at the height of his own oedipus complex.

In each of these cases one may suppose, with Abraham and Freud, that the perception of the act as sadistic derived from the earliest pre-genital impressions. Our presumption would be that at a period in life when the child's own sadistic tendencies have gained ascendancy, he would perceive a sexual act in terms of these tendencies within himself.

In seeking a fuller understanding of such early traumata, we are handicapped by the lack of case material and observational data relative to this early childhood phase. In the literature I have encountered only one contribution to the study of the effects of observations of coitus at a very early age (that is, direct observation of a child's reactions). In a short but illuminating communication from a mother (Anonymous 1927), we learn how a nineteen month old girl cried out in terror one night a few minutes after the intercourse of the parents, who were sleeping in an adjoining room. The child was asleep when the mother came in to her. Thereafter there were nightly recurrences of this scene. She became afraid of her father and regarded him with obvious mistrust. In itself, this might not be too convincing but the mother began to observe how the child was able to sleep through a storm, or through loud noises, but when the parents exchanged caresses, the child instantly woke up crying.

In the case of Sally, we are able to study—through the child's own communications—the reactions to an observation of coitus, only a few months after the observation had brought on a serious illness. We have seen how events in the psychosexual development of this child made it possible and necessary for the child to endow the scene in the room of her grandparents with the sadistic characteristics which then existed in her own mental life. The intensity of these destructive fantasies is vividly brought forth in the period of treatment which immediately followed the analysis of the trauma itself. After the emergence of the memory into

consciousness, there was a torrent of sadistic material which showed the strength of the original impulses

It may be useful for us to bring together the important events which led up to the outbreak of the neurosis. Our analysis reveals that at twenty six months, prior to the observation of the grandparents' coitus, several vital experiences had taken place within a short period of time and at a critical period in the child's development. Certain of these events had brought forth no unusual reactions at the time of their occurrence, but they served the later neurosis in specific ways

The genital examinations had occurred during regular pediatric check ups at Dr. Lawrence's office, when the child was under *two* years of age. The mother could recall no unusual reactions at the time. The birth of Peter, when Sally was *twenty three* months old, was accompanied by reactions which were not atypical for a little girl of her age. Some time following the birth of Peter and before the visit to the grandparents, Sally found the used sanitary napkin in the wastebasket. Despite the mother's unfortunate explanation to Sally, there had been no marked anxiety reactions at that time—according to the mother's report. At *twenty six* months, the visit to the grandparents occurred. The sex play with Danny took place during the two weeks in which the mother remained with the child. While the parents were away, Sally slept in the grandparents' room. One night during this period Sally observed coitus. Her only evident reaction was fear, at that time unaccountable, of the grandfather. Shortly after returning home, Sally became afraid of her father and soon the night terrors began, with the complaint of the noises. At *twenty nine* months, Sally developed the staphylococcus infection which required a program of regular injections by Dr. Lawrence. Once during the injection series, the needle broke at the point of injection and a piece remained in the skin, a detail which played a specific role in the later neurosis. At some point during the injection series, the neurosis took a new turn, the affect became isolated and certain compulsive rituals appeared.

The three critical events—the discovery of the napkin, the sex play with Danny, and the observation of the grandparents—occurred during the three month period which followed the birth of the baby brother. It seems to be of the greatest importance that these events took place at a time when Sally was experiencing the most intense envy of the new brother and the crushing realization of her own inferior equipment as a little girl. When we consider the strength of the sadistic impulses and the relative weakness of the infantile ego, it becomes apparent that these events in the outer world must have appeared as confirmation of the child's most terrible wishes and fears.

At a period in the child's development when inner fantasies must be differentiated from reality and tested against reality, these events in reality appeared to her as proof that the inner fantasies had their counter part in the outer world, hence, that the fantasies were in effect *real*. We have reason to believe that the birth of Peter brought about the first important realization of sexual differences and the conviction that she had been damaged. Within a short period of time, the discovery of a used napkin and the explanation of the mother made real the belief that little girls and women were mutilated. Later in that three month period following Peter's birth, Sally engaged in sex play with Danny. From the analytic material, we have seen that the play with Danny was accompanied by sadistic wishes against his penis. When she wakened one night to observe and overhear coitus between the grandparents, her child's mind obtained additional proof that castration was real. The early stage of the neurosis took the form of a severe sleep disturbance in which, we have reason to believe, some fragment from the observations of that night recurred in the form of a traumatic dream which roused the sleeping child in terror (She wakes up, then she won't hear de noises!) Later, in the twenty ninth month, the injections by Dr. Lawrence provided an accidental proof of a castration fantasy. The same physician who had earlier examined the genitalia (an experience which was certainly accompanied by some pleasurable sensations) was the physician who gave her the painful injections. "The man" had made the 'hole' (vagina), she had told us. "Dr. Lawrence did it with a hatpin" (needle). Even the detail of the needle which broke off leaving 'a little piece' was in literal analogy with her observations of the grandparents and her own anatomical discoveries of the clitoris, "the little piece."

The effects of these experiences on the still uncertain reality sense of a very small child take on a larger meaning when we consider the conditions under which the sexual observation was made. For the small child, the life of the dream is very real. When he awakens from a dream of the pursuing tiger, the tiger is still there in the darkened room. The merciful thought, 'It's only a dream,' is only dimly experienced—if at all—by the child of Sally's age. Usually it is only when the reassuring parents come to the child, when the lights turn on and the familiar faces and voices and the familiar forms of the room are discerned, that the child regains his sense of reality and uncertainly realizes that the tiger is not there. But when the child awakens from deep sleep to observe a night mare tableau of sexual embrace, he sees his most dreaded fantasies unfold before his eyes. The dream becomes real in this sense. And this time the grownups do not come to the child to hold her and comfort her, but spank her for the interruption and guiltily ask each other, 'Do you think

she saw anything?" The behavior of the grandparents and their exchange must have made a deep impression upon the child, for we see how these details survived in the child's memory. It must be that when the child is aroused from his sleep and observes such a sexual act, the sense of nightmare unreality would be very strong, yet would conflict with the child's conviction, "But it did happen!"

It occurs to me that still another factor was present at the time to disturb the reality sense of the child. Sally's parents were absent during this period, when she stayed on with the grandparents and slept in their room. We know how small children feel lost and estranged during the absence of the parents, particularly the mother. It is as if the sense of identity were still, to some extent, dependent upon the physical and psychological unity with the beloved mother. Furthermore, the change of environment in itself seems to disturb small children, whose sense of identity is intimately linked with familiar objects and forms. It is possible that the observation of the grandparents, coming at a time when the child was separated from her mother and in strange surroundings, may have further disturbed the reality sense—because of the ego's greater vulnerability at this time and under these circumstances.

In the course of the analysis we saw that the period of depersonalization was linked with the emerging memory of the sexual scene. ("Mama, I'm not me! This is not our house!") The loss of the sense of identity seemed to be part of the ego's defensive operations in the struggle to keep the repression. The sense of unreality embraced both the memory and the experiencing self. "It did not happen, I was not there. That wasn't me. I am not me!" I have the impression that the depersonalization, which later appeared as a defense against the memory, may also have been linked with the earliest reactions and disturbances of the reality sense which followed the traumatic observations.

We are impressed by the fact that the parents, who normally serve the child as his allies against danger, had lost their vital function. No amount of reassurance or demonstrations of love from them could diminish Sally's anxiety during the early months of the neurosis. Her discoveries in the grandparents' room had established Sally's belief that her parents, too, were such dangerous persons.

The ego of this very small child was threatened from all sides. It was called upon to engage in a critical struggle at a time when it lacked the necessary equipment. It carried on its defensive operations simultaneously against the dangerous impulses within and the dangers perceived in the outer world. It was a struggle without the necessary allies, for the parents themselves had become objects of danger. The ego's vital faculty of reality testing had begun to disintegrate with the fusion of inner fan-

ties and experiences in reality, which seemed to confirm both the sadistic wishes and the most dreaded dangers of childhood. At the time Sally entered treatment, we have the impression that the child had, to a large measure, given up the active struggle.

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THE OEDIPAL PROBLEM OF A FATHERLESS CHILD

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INTRODUCTION

Since the resolution of the oedipus complex is the principal task of a boy during the phallic period, we may assume that the death of his father at this time would be extremely hazardous for his development. Curiously enough, this singularly fateful loss had not been suffered by any boy whose case has been reported in the literature, nor did it occur among the many children described by Anna Freud and her colleagues. An opportunity to observe the oedipal conflict of a child who had experienced this loss was provided by the analysis of five year-old Peter, whose father had died early in the boy's fourth year. Both the boy's symptoms and his transference reactions in analysis showed certain uncommon features, and they posed the question as to whether these variants might be connected with the loss of the rival parent early in the phallic phase.

The Symptoms

At the age of five, when he entered analysis, Peter suffered from severe insomnia, and he feared that his mother would die. To these symptoms should be added a complaint which he voiced immediately after his first analytic hour. Thoughts and voices inside his head kept saying, "Daddy is angry." In a fuller statement, which Peter made when his mother reminded him of pleasant things Daddy had done with him, the boy said, "These people inside tell me about times I didn't like Daddy, times when Daddy was angry at me." With the onset of these symptoms at the age of five, the mother noted also a recurrence of lack of appetite and importunate behavior, problems about which she had consulted me a year earlier and which had in the interim markedly abated.

History

Peter was the second male child in an intelligent, upper middle-class suburban family. The father's business had required frequent absences from home.

¹ I am grateful to Dr. Mary O'Neil Hawkins for reading this paper and for a number of valuable comments on it.

On one of these trips, a few months after Peter's third birthday, the father had suffered a fatal heart attack on the very train that was to have brought him home. The father had been very musical and had devoted much of his leisure time to playing the violin. Peter frequently spoke of the period when Daddy was alive "as being full of music," and would add "there's no music in our house now." The mother described her husband as a meticulous, precise person, subject to headaches of "psychic origin." He had had an irascible temperament, but she could not recall any incidents in which his anger had been directed at Peter, to whom he had been an adoring, kindly and loving father. The first son, Jerry, was two and a half years older than Peter. His development had been atypical and extremely slow. The father had wished to have a second son and was exceedingly proud of Peter, his pleasure intensified by his disappointment in the older boy.

Peter's mother was an intelligent, capable and forceful woman. For several years prior to her marriage she had held a responsible position. Her perfectionism and efficiency made it especially difficult for her to tolerate Peter's stubbornness and wilfulness, the problems about which she had originally consulted me. She had managed her life well, even under very trying circumstances, and she resented her inability to manage her child.² Her feelings about Peter appeared to be in great measure colored by their constant battle of wills. One sensed that the mother could not enjoy Peter, though she described him as bright, alert, and attractive. Her recital of his history was precise and objective, but it lacked warmth, humor, and sympathy.

The mother had felt well throughout her pregnancy and Peter's birth was normal. Since he was a very small child a formula was at once prescribed. His weight gain was slow, and during his first six months he suffered from several respiratory and ear infections. At nine months there was a prolonged period of vomiting and loose stools; celiac disease was suspected. Various diets were tried. A bitter type of milk, which Peter disliked very much, was substituted for the regular milk, which he had enjoyed. The mother believed that the boy's distaste for food dated from this period. The diarrhea and vomiting persisted and at eleven months Peter was taken to a hospital for observation and treatment. He remained there for about three weeks, becoming progressively weaker. The history of this period is incomplete because the parents were allowed only infrequent visits. Peter's celiac disease was less severe than that of many children, but it necessitated the usual deprivations. At the age of three, when he first associated with other children, ice cream, cake, and chocolate—the favorite party menu—were still forbidden.

At home again after the hospital experience, Peter continued to be a weak and sickly child. Because of several respiratory infections and recurrent tonsillitis he spent most of the winter in bed. A tonsillectomy was performed at the age of nineteen months. Peter's older brother, Jerry, had his tonsils removed at the same time, and the mother was allowed to remain in the hospital with the boys.

² I was reminded of Berta Bornstein's (1919) discussion of "the superiority inferiority attitude toward the child."

Shortly after both children had recovered, the parents took Jerry, then four years old, away to school. They had been advised by several specialists to place him in a year-round school for retarded children, and they had finally accepted this plan. During their absence from home a relative came to take care of Peter. When the parents returned ten days later, they were told that Peter had been very difficult to manage. He had eaten very little and had lost weight.

During the following months, however, Peter seemed so well that training—which had not been attempted earlier because of the celiac disease and other illnesses—was begun at twenty-three months. Within a very few weeks, shortly after his second birthday, both bowel and bladder control were established.

Peter was about two years old when his mother became pregnant again. Although she felt well throughout her pregnancy, she developed kidney disease in the seventh month and had to be rushed to the hospital for induced labor. The infant, a boy, lived only a few days. The mother was seriously ill and remained in the hospital for more than a month. During this period Peter was cared for by a German nurse who had recently been engaged. Just before the mother returned from the hospital, the father, who had become increasingly displeased by the nurse's harsh treatment of the child, dismissed her in great anger. The details of this mistreatment could not be obtained.

A few weeks after the mother returned from the hospital, she and the father went to visit Jerry. Peter stayed at the home of relatives while they were away. Again, as during the previous separation, he ate very little and was resistant to routines. These symptoms persisted for some time after his mother's return, gradually abating.

When Peter was three years and three months old, the father suddenly died. For a short period after his death Peter had nightmares and spoke to his mother of his fear of "seeing Daddy at night." He played a great deal with a doll which he called Daddy, caring for it as if it were a baby. Some months later the mother sold their suburban home, moved to the city, placed Peter in a new school, and began to work to supplement the family income. Peter spoke less frequently of his father but constantly asked when they could return to their country home, saying he was "lonesome for it." His refusal to eat and his negative behavior became more pronounced. Though he was not again physically separated from his mother, Peter probably sensed her detachment from him during these months of stress and mourning. It was after their move to the city, when Peter was four, that the mother first sought advice and this history was obtained.

Initial Consultations

When Peter was seen in consultation, a year before his analysis, he was a thin, wiry, small-boned child. Although the mother had thought he might be shy, he came into the office willingly, investigating his surroundings independently and fearlessly. He looked over the toys, commented on several, chose blocks and trains and entered at once into dramatic play. As engineer he took the trains on long trips. As conductor he was very strict about hurrying people on and off the train; frequently people

were left behind because they had arrived at the station too late or because the conductor gruffly gave orders to start the train before they could get aboard

As is so often the case, the play in this first hour was very significant. Peter's game centered on trains, the vehicle in which his father had died and people were prevented, as had been the case with him, from reaching their destinations. Peter, the gruff conductor, was responsible for their predicament. The underlying theme of responsibility for the father's disappearance reappeared in Peter's subsequent analysis and was particularly evident in the transference situation.

Peter's negative behavior, which had been emphasized by the mother, was evident in this session in his response to suggestions. For example, when he was advised not to locate the roundhouse so close to the hot radiator, Peter refused and told me to shut the heat off. The full picture of which the mother complained was revealed when she tried to dress him to go home. As she got one sleeve of his jacket on, he pulled it off, when she zipped the jacket up he unzipped it. His shrieks and screams would have provoked almost anyone to anger. This conduct, his mother said, was typical. Bribery was a frequent solution. This particular scene ended with Peter riding out piggy back on his mother's shoulders, happily and triumphantly coatless.

For several reasons direct treatment of Peter was not undertaken at this time. Pre-eminent was the evaluation of the mother's situation. She did not seem ready, so shortly after her husband's death, to accept a therapy that would center primarily on the child. She herself desired and needed help. It was therefore decided to postpone for the present further contact with the child and to work with the mother instead.

During the period of my work with her she was faced with some new and critical problems in regard to Jerry, the older boy. Her discussion with me revealed her very great attachment to him, an attachment which had seriously interfered with her relationship to Peter. She had never wanted this second son because she felt that she should devote herself exclusively to the older handicapped boy. She had become pregnant again only upon her husband's insistence. She still felt that she should be taking care of Jerry instead of leaving him with strangers. Everything she did for Peter was accompanied by thoughts of the older boy and his greater need of her. Her resentment of Peter's demands accounted in part for her inability to take a firm stand with him. It had been evident in our very first interview that she felt keenly her inability to manage the boy. In the course of our further conferences we came upon many factors in her own history which illuminated this reaction, but of more general significance was the change that took place when she was relieved of the

feeling that somehow she could have managed better. As she accepted my view that any child who had experienced so many unavoidable traumas would inevitably have problems, she began to deal with Peter more effectively. She began to feel that he needed her, as much, perhaps, more, than Jerry. The effect on Peter of the mother's changed attitude was very marked. His behavior improved astonishingly as she shifted much of her love and attention to him. He began to eat well without coaxing and showed independence in caring for himself. His importunate demands lessened so much that his mother began to enjoy his company. After about four months she was so pleased with his progress that she thought further conferences were unnecessary.

It was about six months later, at the time of Peter's fifth birthday, that the exact set of symptoms developed and analysis was undertaken. The boy now began to suffer from severe insomnia and feared that his mother would die. He compulsively questioned her about this possibility. At night, unable to sleep, he would run to her room to reassure himself that she was still there and to ask again and again how she could be sure she wasn't going to die right away.

MATERIAL FROM THE ANALYSIS

Fantasies About the Father and Castration Fears

We had seen Peter a year earlier managing the coming and going of trains and the destinations of passengers, thus symbolically displaying his ability to make people disappear. He gave a different picture in his first analytic hour. He played he was an "angry hunter" who was shooting all sorts of wild beasts. Then the hunter became angry at the sky because a voice up there was saying "I'll whip you." As Peter lifted his gun to shoot, it was he himself who was killed. In this game a voice from the sky, surely that of the father, threatened the boy while he was engaged in aggressive activity. Peter played the role of an angry hunter, but the voice in the sky was angry too. It was after this hour that Peter's complaints of thoughts about an angry Daddy were first expressed. In this game, in contrast with that of the previous year, there was retaliation and anxiety.

As might be surmised from these two hours, and as the later analysis clearly indicated, Peter had developed a positive oedipus complex. His rivalry with the father and his desire to take his place with the mother had been aroused prior to the father's death. The father's disappearance thus occurred in a period in which the boy had ambivalent feelings toward him—tender feelings of long standing and more recently aroused aggressive ones. During the early weeks of the analysis, these opposing feelings were very evident. Even when Peter complained most bitterly of

voices telling him that Daddy was angry and not a nice Daddy, he spoke with me of happy times he remembered having with him. He had loved to listen to him play the violin. He remembered with pleasure how Daddy came home and asked for Peter, looking for him right away so that they could play together. When asked why this Daddy whom he missed so much was angry, Peter could only reply, "I don't know."

Peter's ambivalent feelings were most fully expressed in a cowboy game which he initiated several months later and which he carried on for a prolonged period. In this play, Peter, as the Lone Ranger, acted the part of an intrepid leader who was a keen shot and who knew all sorts of tricks and camping lore. It was revealed after a while that he was adept and invincible because his father had taught him all these things. The father had been dead for many years and since his death Lone Ranger had lived with a pal. During the father's lifetime, however, he and Lone Ranger had lived on a very beautiful ranch far off any known trail. It had been quiet and peaceful, the house surrounded by lovely old trees. One day the site of Lone Ranger's boyhood home was found. Some old trees made him think it might be the place; then it was definitely recognized by the presence there of a musical instrument. In reality the musical instrument was an accordion which Peter had brought to his hour wrapped in a paper bag. He had placed the bag in a corner and let it remain there until he found it in the game. The similarity of the packaged accordion to a violin in its case—an instrument closely associated in Peter's mind with his father—was striking.

In this cowboy game the dead father was found at the bottom of a swimming pool. In subsequent hours he was revived and carefully nursed back to health with good food. He was indeed reborn for his convalescence took place in a room of the old house which was connected to the swimming pool by a pipe. One had to push very hard at the door at the end of the pipe in order to enter the room. When the father became stronger, Lone Ranger bought him a new horse. Father's old horse had been killed; it appeared by Lone Ranger's steed, but Peter assured the father that now their horses would not fight any more. In other hours Peter played this same theme in reverse. Miners had been trapped. Peter filled in the mine openings so they could never escape. He left them to starve down there.

Peter clearly was not sure whether he wanted his father to be alive or dead. At times it seemed that thinking of father as alive again made castration more imminent, but the threat existed also if he were dead.

Some of Peter's fantasies about his dead father were influenced by what he had been told by a Catholic maid who was in the household at the time of the death. Peter believed that Daddy lived in the sky or

heaven and would reappear on Red Cross Day—his rendering of Resurrection Day. He also believed that father, though invisible, could see and know everything Peter did, so that he always knew whether Peter was good or bad. This concept was particularly terrifying because Peter believed that his father didn't like penises and did not think Peter should touch his. Peter expressed these ideas indirectly in play and directly in conversation.

One day, while urinating, Peter said to his mother, "Mary [a maid whom they had had some months before] said this could be bitten off, but that's a joke isn't it?" His mother assured him that no such thing could happen, but not until he expressed his fantasies about what Daddy thought and might do was it possible to allay Peter's anxiety by assuring him that Daddy, if alive, would have responded just as his mother had.

In the analysis of Peter's castration fear we came upon some of the determinants of his thought, "Daddy is angry." He always spoke these words with a pronounced German accent. It became evident that he was parrotting the German nurse who had cared for him when his mother was in the hospital. It was she, not the maid Mary, who had made the castration threat. Indeed it was plausible, though never proved, that this was the action which had so angered his father and precipitated her abrupt dismissal. Peter expected that the castration predicted by the nurse would be effected by his intemperate father. This is, of course, a common fear in little boys; in Peter's case the fear was particularly intense because his father had become an angel who was invisible, yet all-seeing. Peter thought, furthermore, that his father had good reason to be angry because, as the analysis later revealed, he understood his father's disappearance as the fulfillment of his own wish.

This fear of an omnipotent and omniscient parent might also occur in a child whose father was alive, but such a child would have at least the opportunity to test his image against reality. Peter could not. No actual figure gave him cause to modify the fearsome, avenging image which he had formed. His father was not there to continue giving and evoking affection, nor to reassure Peter by his presence that wishes are not the same as deeds.

Toward the end of his analysis, Peter's play indicated that a change had taken place in his image of his father. During this period he enacted the role of a new character—Straight Arrow. Straight Arrow was upright and courageous, but his most distinctive attribute was a precious Golden Arrow that could never be taken from him. Straight Arrow turned out to be the long lost son of the Sheriff. He was made head of the posse, and when not engaged in upholding the law, he and his new-found father enjoyed listening to victrola records! Though there was no living father

with whom Peter could identify and make his peace, he had adopted a father figure who symbolized law and order and in whose footsteps he was resolved to follow. The fantasied angry father had been replaced by a just but kindly one, and castration was no longer a threat—Peter's penis, like Straight Arrow's Golden Arrow, was his forever.

The Symptoms in Relation to the Father's Death

Peter's insomnia and his conception of an angry father were connected with another fantasy about his deceased parent. The boy thought that his father now lived in Cockadoodle Land—a vague place, rather like heaven. He believed that his mother and father met there at night though his mother would be back in bed if he went into her room. Perhaps she did not even know she left her room, she might think she was asleep, but actually she met Daddy each night in Cockadoodle Land and there they kissed. With this information, it was easy to understand why Peter could not sleep but prowled about the house after his mother had retired. This fantasy was also related to the boy's concept of the angry father, for surely if Daddy were waiting for mother in Cockadoodle Land, he would be angry at Peter for delaying their meeting and for making mother return to earth again by coming to her room. After this fantasy had been interpreted to the boy, he revealed feelings and wishes of the period preceding his father's death. He enacted the story of a little boy who would not stay in bed. Because this child rode his bicycle in the park at night, his father had to get up and chase after him. The boy's aim was achieved when he eluded the father and "jumped into the Mommy's bed." Then, when the father came home, he had to sleep in the little boy's bed. In a conversation about this little boy, Peter recalled his own feeling of loneliness at about the age of three, when he had lain alone hearing his parents whispering in the adjoining room. Like the boy in the game, he had wished that he could take Daddy's place with Mommy.

Peter's insomnia and fear of his father's anger were thus the consequences of rivalry—a rivalry which antedated the father's death. We might conjecture that even if his father had not died, Peter would have been troubled by insomnia and gone prowling at night, but he probably would not have been afraid that his mother would die. His anxiety stemmed from his belief that the parents would be reunited through the mother's death. The anxiety was not—as is more usual—due to his death wishes. Instead, it expressed the boy's fear that mother and father would thus be together, leaving him once again quite alone. Although Peter's anxiety about his mother—an anxiety not customary in a boy during the oedipal period—may have been reinforced by early periods of separation, its primary cause was the death of the father.

We cannot be certain what factors precipitated the appearance of Peter's symptoms around the time of his fifth birthday. We may conjecture that a biological increase in the phallic drive reactivated the boy's conflict. Another possible explanation is the effect of my earlier work with his mother. As a consequence of it she stopped forcing food. Her new approach led to a diminution of the child's oral-sadistic relationship to her. Furthermore she became more affectionate. The boy's response to this may well have intensified his rivalry with the father. Peter's symptoms could have been due, then, to a shift in the relative strengths of the oral and phallic drives and to an intensification of his libidinal relationship with his mother. All of this, in turn, would have reactivated fear of, as well as rivalry with, the father.

Transference Reactions

One unusual feature of Peter's analysis was the intensity of his transference. This development, infrequent in the analysis of young children,³ poses some questions. Were the transference reactions evoked by the circumstances surrounding the treatment, or were they related to the loss of the father at a critical period of development?

The treatment was conducted in the analyst's apartment and Peter occasionally met her husband in the elevator or waiting room. During the summer the interviews were held at a country home which reminded Peter of his former house, for which he had long been "lonesome." Peter especially enjoyed his visits during this vacation period, and the circumstances may have increased his positive feelings. Since Peter was an attractive and intelligent child, with a delightful sense of humor and a vivid dramatic flair, he evoked warmth and affection in return.

When Peter started analysis at the age of five, he was troubled and anxious. He consciously wanted help. His mother had explained to him the purpose of his visits to me, and he quickly developed a strong positive attachment. After a few hours, in which he had assigned me the role of a mother in a game in which he was the father, he asked his mother whether I had "a man." Some weeks later, when he first encountered my husband, a six-footer, Peter told me that he wanted to be very tall when he grew up. As the analysis proceeded, Peter's mother noted that he deliberately avoided looking at my husband, if they chanced to meet.

The necessity for avoidance was so great that Peter gave up a much desired treat—a ride on a tractor—because it would entail being with my husband. The first day we worked in the country playroom, which was located in the barn, this tractor had attracted Peter's interest. When

³ Among the cases reported in the literature, the most similar transference reactions are those of Wachtel's (1946) seven-year-old patient, Anton.

he asked if I could drive it, I answered factually that I could drive it but was not able to start it, since it had no battery and needed to be cranked. "Can I have a ride?" was the next question; I answered that he surely could. Someday we would ask my husband to start it. "He should start it and then go right back into the house," said Peter. He played that he ran an auto school and was teaching me to drive. I suggested that he wished he knew how to start the tractor so we wouldn't have to ask my husband. Peter never asked for his promised ride, passing the tractor each day as if it did not exist. Weeks later, toward the end of the summer, Peter stopped by the tractor and screamed at me, "Why don't you drive it?" I explained again and inquired if I should ask my husband now to start it for us. "No, I don't want him here." "You think everything should be just for you and me?" I inquired. "Yes, that's the way it's to be." So the summer passed, and he never had his ride.

On the very last day of the vacation Peter could not avoid meeting my husband. Since his mother was unable to start their car, my husband went out to help. When I introduced him, Peter looked at him from under lowered brows, then almost ostentatiously turned away. Though very interested in cars, he kept his distance and never said a word while my husband located the trouble and started them on their way. At the next interview, back in town, Peter played that he was a mechanic fixing the wires on a car. This had been the trouble with their car, and I commented on the parallel. Peter said, "He fixed it." "You mean my husband?" "Yes, he knew how to do it." I reminded Peter of his avoidance of my husband and suggested that he had foregone watching him repair the car just as he had foregone the promised tractor ride because he did not wish to be reminded of his existence. Peter made no comment but continued to play that he was the service man who knew how to repair stalled cars.

Peter's unwillingness to share me was not confined to my husband, but extended to other child patients. Thus both oedipal and sibling rivalry transference reactions were manifested. At first I noted that he was very aggressive if he met another child in the waiting room. I could be sure he had encountered one if he began his hour by hitting me. Shortly it became exceedingly difficult to terminate the period. The ending of the hour signified that I was not entirely his and also reactivated feelings connected with early separations from his mother and with the loss of his father. When Peter had been in treatment for a year, his behavior at the end of the hour had become so violent that he interfered with the next child's appointment and I was forced to take an exceptional step. For about a week I went to his home instead of having him come to me. Since interpretations had been of no avail, I was unable to

avoid this realistic, nonanalytic action Peter's feelings were so intense that it seemed as if they had to be denied by reality, which was what the procedure conveyed to him. Only then were the previously ignored interpretations accepted. This incident could not be viewed simply as an indication of the strength of Peter's wish to have me all to himself. It stemmed from his many experiences of separation from a love object and his loss of his father.

In a later period of the analysis Peter showed another interesting transference reaction. His castration fear had by now been somewhat mitigated and he had enacted his old wish to take his father's place in his mother's bed. Then there came an hour in which Peter for the first time accepted the fact that fathers have some privileges which children may not share. When leaving that day Peter looked over the mail in the foyer, as he often did, and pushed the letters addressed to my husband under the door that led to his workroom.

Toward the end of the analysis, when Peter's phallic desires were strong and urgent, he came close to forming a transference neurosis. He became unusually calm and detached at home. Unlike his former self, he demanded very little of his mother's time or attention, no longer coming to her room at night. But in his hours with me he was extremely excited sexually, and his games involved more and more physical contact with me. He attempted to climb all over me and burrow into me. He tried to mask this behavior in a game, in which he was a cowboy who was going to marry me, but it was no longer a game. He was consciously seeking physical contact with me. I had to tell him that he could not act this way with me and could never marry me, that I was there only to help him. Because of the intensity of his feelings, it was difficult to show him that they were a reenactment of those he had felt for his mother and that his angry response to my words paralleled his feelings as a little boy when he was excluded from his parents' bedroom.

During the following hour, Peter said, "Your name is Mrs. Meiss, isn't that so?" Though he had always called me by that name, it was only with this question that he fully accepted the connotation of this appellation. I reminded him then of his meeting with my husband and his behavior on that occasion. Peter replied, "I was silly then. I couldn't really make him disappear." It was thus through his transference reactions that we came to the nexus of Peter's problem—his wish to make Daddy disappear, and the trip from which Daddy never returned. All this had happened before Peter understood that thoughts and deeds were not the same, before he knew his wishes could not have caused Daddy's death. No wonder, then, that he had been afraid and that he had thought Daddy would be angry.

It was only in this latter phase of the analysis that Peter was more interested in me than in his mother. During the earlier period, when his oral and anal sadistic drives had been in the foreground, he had used both of us indiscriminately as his objects. With the stronger development of his phallic desires, he turned from the mother to me. Throughout the analysis Peter had quite consistently used my husband as a substitute for a father. He manifested both his wish to emulate him and his wish to make him disappear. His transference enactment of his desire to possess the mother and to displace the father was unusually intense for so young a child.

The circumstances surrounding the analysis must be given consideration in evaluating Peter's reactions, but I wish to put forward the hypothesis that his transference would not have been so intense if there had been a living father.⁴ It was on the basis of the presence of the parents as love objects that Anna Freud (1946) explained the absence of transference neurosis in children. Peter had only one living parent, and we should perhaps not be surprised that he displayed an uncommon transference reaction. His overwhelming fear of his dead father may have made it too dangerous for him to return to his original object. The analyst was safer because her husband seemed less threatening than his invisible and omniscient parent.

In her recent discussion of transference reactions in children, Selma Fraiberg (1951) makes an observation that might be used in support of this hypothesis. She suggests that when the oedipal complex is reactivated, the child—because of his inadequate superego organization—can once again seek gratification through the original objects, whereas the strong superego of the adult does not permit this. In Peter the dread of the deceased father may have had somewhat the same effect as the superego of the adult. And we may go a step further. Is it not possible that through the process of mourning for the father there was an unusually early identification with him, with a concomitant internalization of his supposed demands, at a time when for other children these demands are still external?

SUMMARY

This paper has presented the oedipal problem of a five-year-old boy who had lost his father at the age of three years and three months. The

⁴ If Peter's mother had been contemplating marriage or spending much time with one man, it is probable that the oedipus complex would have been enacted outside of the analysis instead of in it. Peter had never had cause to transfer either his libidinal or his aggressive impulses to any male figure in his environment. This factor certainly contributed to the development we are considering.

boy came into analysis shortly after his fifth birthday, when he suffered from insomnia, anxiety about his mother, and obsessive thoughts about his angry father.

The course of the analysis disclosed the relationship of these symptoms to fantasies about his deceased father toward whom, when alive, he had already developed aggressive feelings. The father had become for the boy an omniscient, angry and avenging figure who disapproved of masturbation and threatened castration. The child thought that his father resided in Cockadoodle Land and that his mother met him there each night. His insomnia and night prowling represented an attempt to prevent this meeting. He believed that this behavior would arouse his father's anger; but another, more compelling, cause for the father's ire was the boy's old wish that he should disappear. Since there was no actual father present to reassure the child that wishes are not the same as deeds, or to continue giving and evoking affection, his fearsome image could not be tested against reality. Through the analysis this terrifying father image was replaced by a just but kindly one.

Although this boy might have developed insomnia even if the father had not died, his anxiety about the mother probably would not have appeared. This anxiety stemmed from his fear that through her death the parents would be reunited forever, leaving him quite alone. This symptom was not, as far as the analysis went, the result of antagonism toward the mother but was derived from the boy's rivalry with his deceased parent. Since anxiety about the death of the mother is rare in boys during the oedipal period, this symptom may perhaps be uniquely associated with the death of the father prior to the onset of latency.

Another uncommon feature of this case was the development of the transference. During the latter period of the analysis the boy turned from the mother to the analyst, wishing to gratify his phallic desire with her. While he behaved in a calm and detached manner at home, he was excited sexually during his analytic hours. He re-enacted and further developed his early relationship to his father by manifesting hostility toward the analyst's husband and at the same time emulating him. Both his oedipal desires and conflict were transferred into the analytic situation and could there be interpreted.

These usually intense transference reactions posed a question. They have been related to the boy's overwhelming fear of his deceased father, a fear so intense that it was too dangerous for him to return to his original love object. It has been suggested, too, that the death of the father have promoted a precocious internalization of his prohibitions, and that this would account for the transference of the oedipal conflict into the analytic situation.

On the basis of our theoretical and clinical knowledge we would expect that the death of the father early in the phallic phase would have fateful results. In this child, the consequences were such that analysis was essential to a normal resolution of the oedipus complex. At the present time it is impossible to compare the unusual symptoms and transference reactions of this case with other instances because none have, to my knowledge, been reported in the literature. Only further investigation will prove whether or not these developments are typical of boys who have lost their fathers during this critical period.

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SUBLIMATION IN A GROUP OF FOUR-YEAR-OLD BOYS

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Eddie, Bobby, Dennis and Roger were a group of boys between the ages of four and five, whom I had the opportunity of observing in a nursery school over a period of nearly a year. They afforded an interesting study of the way in which young children can overcome their difficulties by means of sublimation.

Bobby, when I first knew him, was at the height of the oedipus conflict. He was a lively, attractive child, but was having great difficulty in dealing with his aggression, and had to be disciplined rather severely by the staff (which made him all the more furious). One day, he was sitting beside me in the garden, unusually silent and serious, after a long time, he suddenly said "When I'm big, I want to be a German, because I want to shoot people." I asked him whom he wanted to shoot, and he replied "I want to shoot my dad." On another occasion, some time after I had had to check some specially aggressive attacks he had been making on other children, he saw me reprimanding another boy, and immediately began to look very angry and resentful himself, he then began to tear up an old doll's sheet, and said to me, scowling fiercely "I'm tearing this because I don't like you." His mother at this time was worried about his defiant and disobedient behavior at home. At the same time, he had always showed exceptional imagination and powers of observation: a charming instance was given one day in spring, when he suddenly noticed a tree in the garden outside, and called out in great excitement "Come and look at this tree out here, how green it is—it's all new, isn't it?—it's all new!"

Dennis was a small, energetic boy, who was exceptionally neat and tidy; he hated to get dirty, and was extremely proud and careful of his clothes. He was well behaved and amenable to discipline as far as his actions were concerned, but his aggression took the form of shouting everything he had to say in a most hostile manner. Moreover, for a long time he used anal language to an excessive extent: the word "shit him" occurred in almost every sentence, and was used as a verb, adjective and adverb as well as a noun. Other children were seduced into imitating this talk, and the staff used every means they could think of to put an end to it—but without avail, until the events which I shall shortly describe. The positive sides of Dennis' character were his really intense energy, a power of concentration and a kind of competence and thoroughness which made him

carry through any activity he undertook in a way unusual for a child of his age

Roger was an undersized, pale, delicate looking child, who, at the beginning of the year, when he was just under four and had recently started at Nursery School, was behaving in a babyish way, crying hutterly when his mother left him in the morning and often too when he wakened up from his afternoon sleep, clinging to members of the staff, and being unable to mix with other children and to take part in activities as he should have done by that time. He frequently wet himself during the rest period, and occasionally at other times, and was very ashamed and upset when this happened. He had a very individual sense of humor, and used to make whimsical remarks, with a comical expression on his face, in a most engaging way.

Eddie had always seemed a fairly well-adjusted child. He was alert and self possessed, and was usually engaged in some interesting and constructive activity. He had, however, given evidence of strong castration anxiety, in paintings of 'men with their noses cut off, all bloody, and drawings of pans and other objects with long prominent handles. From time to time he had an outburst of rather pronounced unruly behavior, attacking other children and refusing to obey instructions.

After these problems had been engaging our attention for some time, and we had felt we were not making much headway, we noticed, all of a sudden, as it seemed, that we were not having any more trouble with these boys, and that they were always together and always doing something that seemed to be of absorbing interest to them, they were usually out in the garden, and the only difficulty was in getting them to break off their fascinating occupations and come in for meals. I began to take notice of their games, and these were some of the things they did in the course of a few weeks.

Cricketers.—One morning they got hold of a bat and ball, and themselves made wickets and bails from twigs. They modestly said they were learning to play cricket. Dennis said he was Dennis Compton. In the afternoon they started again, and this time arranged boxes and chairs in a circle, and persuaded other children to sit and watch their cricket match, instructing them to clap when anyone hit the ball. They made up various new rules, e.g., the batsman was out if the ball hit his legs or feet.

Decorators.—They got strips of colored paper, and with great ingenuity fastened them round the window frames of the garden hut, to make it look nice.

'Beer Men'—They sat inside a large box, sipping water from dolls' cups, and said they were drinking beer, they also talked about whisky. Later they made a big box into a lorry adding wheels and tyres, they put smaller boxes inside, and said they were delivering beer.

Gardeners (1).—They dug up weeds and sods and arranged them carefully

round the base of a large tree growing in the asphalt playground, then placed chairs on them and invited the staff to come and sit in their garden

Gardeners (2)—They collected a large number of wooden boxes, and put in them earth and water, then weeds, handfuls of grass and leaves

"Punch and Judy Men"—After a party at which we had a Puppet Show, they several times played at this game, with dolls for the puppets and blankets for the curtain concealing the puppet men. They imitated the noises made in a 'Punch and Judy' show most realistically. During these games, Dennis usually took upon himself the role of serving refreshments to the spectators

"Rag and Bone Men"—They put some doll's furniture in a doll's pram, and went about trying to sell it

"Bombers"—They were playing on a big old tree which had been felled and lay in the playground. It was a bomber, the largest of the branches was the gun. Eddie had a rag and was rubbing away at the tree—he said he was "dusting and shining" the aeroplane—and pointed out the parts where the bark had come off, saying they were shinier than the other parts. They had a small tyre for the steering wheel, and showed me which branch was the propellor. They pointed to a bombed building nearby, and said they had 'bombed it on fire', also, noticing smoke coming from another building nearby, they claimed to have 'bombed that on fire' too

Red Indians—The day after a Red Indian game had been started by one of the staff, Bobby and Eddie arrived with Red Indian headdresses made at home. Soon they all started to dig up earth to make a campfire, and busily collected a large pile of twigs, Eddie produced a box full of spent matches. Then they tried to re-erect the tent we had had the previous day, they found the blanket, the three poles and some string, and made a very creditable attempt at putting the whole thing together

Red Indian Canoes—Eddie and Bobby sat astride a log and used long sticks for oars, they found a long piece of rope and busied themselves with it around the log—Eddie said they were "fixing the electric." Later they were looking for another piece of rope, so that if an Indian fell into the water they could pull him out—or they could tie the boat to the shore if they wanted to

Fishing—Two were sitting on one log, two on another. They had a large net for fishing, and ropes for fishing lines and for catching anyone who fell into the water. They had some old petrol tins with water in them, and Roger was pouring water into the holes in the logs, and said he was "oiling the engine." They had tyres around the boats for life belts, and sticks for oars as before. Later they stopped fishing and began taking passengers to the seaside in their boats

Mending Windows—Bobby and Eddie pretended that the windows in the cloak room were broken, and mended them.

Window Cleaners—One of their favorite games was to get rags and buckets of water, and to spend hours "cleaning" the windows of their playroom.

Swimming—They emptied all the water out of the water play bath, it spread

around the playground, and they said it was the sea, and ran about making swimming movements

Tree Cutters (1)—Roger brought a rubber hatchet to school, and they pretended to cut down trees with it

Tree Cutters (2)—I visited the Nursery School one day after I was no longer working there, Eddie and Bobby had left, and Roger was absent. Dennis and another boy were half way up a small tree, on ladders, and said they were cutting logs and were going to sell them to get money for toys

Letter Writers and Postmen—Eddie brought some stamps, and the four boys spent a long time writing letters, putting them in envelopes, sealing them and putting stamps on. Then they made a postman's van from a climbing frame and some tyres, and delivered the letters

Taxi Drivers—Dennis and Roger made a taxi from various boxes and pieces of climbing apparatus, they were the drivers, and had two other boys in the back for passengers

Builders—They made a large and complicated structure from blocks and said they were 'building the Festival of Britain'

Trains—A train game was started by one of the staff. They took this up with zest, and made, with chairs, two rival trains. Eddie and Bobby had one train, Dennis and Roger the other, and each pair tried to persuade the grown ups to ride on their train, by bribing them with offers of sleeping cars and dinner on the train. They bustled about with toy cups and plates, serving tea and coffee. Eddie and Roger got tins and made rattling noises reminiscent of the noise of a train, Bobby made screeching noises, a very good imitation of an engine whistling. Roger poured water from a doll's teacup into an old tin can—petrol for the train.

Firemen—They frequently played at firemen, dashing about on their fire engines and putting out fires with water and pieces of hose pipe

Soldiers—They were in the garden hut, and said they were in the 'Theseus', and were going to America, also to Korea, to do away with all the bad people.

'Jungle Men'—Eddie and Roger were crawling on all fours and said they were tortoises. Dennis and another boy were driving them along with whips, and Bobby was walking alongside with a tin full of grass feeding the tortoises

Boy Scouts—Another boy started this game, and the four joined in. They made 'badges' from sticky paper and stuck them on their shirts. They played again the next day, and tried to get other children to join in, telling them 'you only have to go about doing jobs'

Barbers—Some months after they had all left the Nursery School, I saw three of the boys again, and they asked me 'Do you remember how we used to play at barbers at the Nursery School?' They told me that when, at washing times, they used to put water on their own and each others hair, they were pretending to wash and oil their hair. At the time I had not realized what they were doing, and thought they were just messing with water.

There were a number of interesting features about the play of these

children, compared with that of others of similar age at the Nursery School. The strength of the relationship between the four boys was particularly marked. As indicated in the examples, they willingly played with other boys at times, but on the whole preferred to be just with each other. They hardly ever played with girls. Sometimes they split into pairs, but usually all four were involved in whatever they were doing. There was remarkably little quarreling between them; occasional flare-ups did occur, certainly, but as a rule they played very happily together. And it was very difficult to find out if any one of them was the leader, or if they all contributed an equal share in the initiation and organization of their games. The only hint I got about this was that, when Dennis was absent, there was a slight falling off in inventiveness and concentration.

The comparative lack of exhibitionism was another striking feature; the other four-year-olds in the Nursery frequently drew the attention of the staff to whatever they were doing, inviting praise and interest; but these boys were, as a rule, content to get on with their games without drawing attention to themselves. (The exceptions, in the games I have recorded, were the Cricket Match, the "Punch and Judy" game, the Train game and the Garden, in all of which they invited an audience or made a bid for the favors of the staff.) Apart from these instances, if I wanted to know what they were playing at, and it was not clear from just looking and listening, I had to inquire, and when I did, they were always ready with an explanation, always quite clear as to what they were about and what they were going to do next. When I questioned them, it was not one particular member of the group who gave the explanations—all four were equally ready to come forward with a lucid and sensible reply.

Although the notes I made are very brief, the activities did in fact go on for a very considerable time—often as long as one and one-half hours. The fertility of their invention seemed inexhaustible; although, as indicated, they were always ready to follow up ideas suggested by other children or members of the staff; they were never at a loss for ideas themselves, and never asked for suggestions. When other children were drawn into their games, it was in a passive role (e.g., as passengers in the taxi and in the boat). These boys all appeared to be of well-above-average intelligence, though none of them was outstanding in his own right—it was only when they came together in a group that they appeared to be of outstanding ability, collectively.

The other children in the group appeared to understand that these four wanted to be together, and mostly left them alone, though they readily joined in when invited. They were well liked by the other children, and were regarded as the "big boys" of the group; they were re-

liable and willing helpers to the staff in things like carrying messages and acting as "waiters" at mealtimes. In short, after being children about whom we were worried, and who were (except Eddie) troublesome and unhappy, they found ways of dealing with their problems which were acceptable both to themselves and to their environment.

It should be mentioned that there were in the Nursery School eighty children, aged two and one-half to five, divided into three groups each of twenty five to thirty children, each group having a nursery school teacher in charge, and two assistants. For all day to day activities, each group formed a separate unit, and the boys were all in the same group.

THE DEFINITION OF SUBLIMATION

The task of defining sublimation is a complex one, the difficulties are indicated, for example, in papers by Glover (1931) and Flugel (1942). It will be helpful if we look at our material and consider what is happening in the play of the four children. We see that in their games they are using the following impulses:

Anal urethral impulses (play with water, earth and weeds)

Exhibitionistic impulses (in the Cricket Match and the Punch and Judy and Train games)

Aggressive impulses (cutting down trees, setting things on fire, whipping animals, killing people)

Creative impulses (constructing things—vans, boats, tents, fire engines, etc.)

Oral impulses (delivering beer, handing round refreshments, feeding the animals)

Curiosity not directly shown in the examples, but shown by the fact that they had knowledge about many different things.

There is also evidence of the need to make reparation, in such activities as cleaning, mending, making things nice, doing away with bad people, and Scouts doing good deeds.

Turning to the individual children, we see the following impulses:

Bobby: Aggression against his father and other authority figures.

Dennis: Anal sadistic urges—his pleasure in dirt overcome by becoming excessively clean, and aggression, causing him to shout. Perhaps strong oral impulses also underlying the shouting and the anal language, and contributing to his liking for feeding other people.

Roger: Aggression against his mother, causing him to be distressed when she left him at school. Aggression projected on to other children, causing him to fear them. Urethral urges.

Eddie: Aggression, projected and leading to castration fears, also leading to unruly behavior.

It becomes clear that the impulses originally causing the children to indulge in unacceptable behavior are the same ones which later provide

the driving force for their socially acceptable and enjoyable activities, namely, the aggressive drives and the pregenital component instincts. These drives, instead of being repressed or continuing to be directed to their original goals (ways of dealing with the original drives which can lead to symptoms or perversions) were in some way transformed, and displaced onto new goals. Recent writings of Hartmann (1950) and Hartmann, Kris and Loewenstein (1949) have dealt at length with problems concerning the mental energy used in such activities as play, work, hobbies, and cultural pursuits, and with the complicated processes whereby the energy is transformed. Kris (1952, pp 26-27) gives the following formulation:

Sublimation, listed also as one of the defense mechanisms of the ego, designates two processes so closely related to each other that one might be tempted to speak of one and the same process. It refers to the displacement of an energy discharge from a socially unacceptable goal to an acceptable one and to a transformation of the energy discharged, for this second process we here adopt the word neutralization. (We do so since sublimation when used to designate energy transformation tends to designate that of libido only since we assume that the transformation concerns both libido and aggression, the term 'neutralization' offers better opportunities to avoid misunderstandings.) The usefulness of the distinction between the two meanings becomes apparent when we realize that goal substitution and energy transformation need not be synchronous: the more acceptable, i.e., higher activity can be executed with energy that has retained or regained its original instinctive quality. We then speak of sexualization or aggressivization.

SUBLIMATION AND THE OEDIPUS COMPLEX

It is certainly not without significance that these children began to be able to sublimate successfully when they were in the oedipal phase of development. The connections between the oedipus complex, superego formation, identification, castration anxiety and sublimation are well known (Freud, 1924). Besides taking account of the stage of instinctual development which determines the type of sublimation possible to an individual at a given time, we must also remember that a certain degree of ego development and physical development is necessary before a child can carry out the type of activity here described. (It has been noted that the four boys were all endowed with good intellectual ability, and that Bobby in particular was a gifted and imaginative child, if this had not been the case, the children's activities would have been on a different level, whatever the quality of the instinctual drives.) Taking all

these factors into account, we can see that the activities are to some extent typical for the boy of about four years

Yet there are certain aspects of the play of these boys which indicate that they had found a somewhat unusual way of overcoming their difficulties. The boy can deal with the oedipus complex either by becoming like the father, identifying himself with him in order to gain the mother's love, but finally giving up the libidinal attachment to the mother, or by identifying himself with the mother in order to become the passive recipient of the father's love. It was the first course, the one that leads to normal development, which was adopted by the four boys—not the second, which leads to homosexuality. But they dealt with the situation in such a way as to give themselves plenty of scope for satisfactions of a homosexual type. In every one of their games they are imitating masculine occupations, sports and hobbies—are being, in a sense, thoroughly masculine, yet they hit on activities like drinking in public houses, Boy Scouts and various jobs in which men work together which, when carried out by grownups, lead one to infer a more or less latent homosexual element.¹ Even when their play took them into more domestic regions (which was very rare) there was still this flavor, one day I noticed Eddie and Dennis walking along with their arms round each other, one of them carrying a doll, and I thought that perhaps they were playing at mother and father, and that for once one of them was adopting a feminine role—but when I questioned them, they told me that Eddie was the Daddy and Dennis the Uncle. Perhaps it was the dangers involved in assuming the masculine role, the imagined threat from the father if one becomes too much like him and thus liable literally to take his place, that caused this particular solution to be adopted by the boys.

Castration anxiety has been specially noted in Eddie, and although there were no specific evidences of it in my individual observations on the other children, there was a quality about their activities which made one feel that it was perhaps very strong in them all and was one of the factors underlying their determination to be masculine at all costs. There was an incident one day which seemed to reveal a sort of group castration anxiety, Eddie, Bobby and Roger came running in from the garden looking really frightened, and saying 'Come and look at that tree outside—it's broken—it's falling down—come and look, quick!' They had been upset by a tree which grew out of the ground at an angle, instead of standing straight up, and which they had evidently noticed for the

¹ When this paper was read at a General Meeting of the Hampstead Child Therapy Course Miss Anna Freud observed that there was a striking resemblance in some respects between the behavior of these children and that of adolescents in the homosexual phase of their development.

first time. Since all the boys gave signs of having very strong aggressive urges, one would have expected the castration anxiety to be particularly severe.

SUBLIMATION AND THE ENVIRONMENT

In addition to the psychic elements, the child's environment has a part to play in deciding whether he develops the capacity for sublimation and the form which the sublimation will take. Anna Freud (1948) sums up this aspect of the problem when she writes: "While an unduly severe and restrictive upbringing may prepare the way for all sorts of neurotic disturbances, excessive freedom for instinct gratification, with a lack of educational guidance, predisposes the child to social maladjustment." The four boys described were all fortunate in that they came from good, stable working-class homes, where the parents knew how to maintain a balance between overpermissiveness and overrestrictiveness. (The only exception was that I felt Dennis possibly had an overstrict training with regard to cleanliness, but I did not have any information on this point.) One can speculate about how Bobby and Dennis, for instance, might have produced delinquent behavior, or symptoms, instead of sublimating, if their environment had been less favorable. If Bobby had not been helped to control his aggression, he might have become a rebel against all forms of authority, or his aggression might have turned against himself, if he had been either too severely or too leniently treated. Dennis had already produced a rather severe reaction formation against his anal urges, and might have gone even further in this direction if he had not had an environment which made it possible for him to find a healthier way of dealing with his problems.

The good home background was reinforced by the gentle but consistent discipline of the Nursery School, and it was at the Nursery School that the boys were provided with the space and materials needed for their activities and with the opportunity of meeting each other. It would have been most interesting to have been able to present details of the stages by which the boys came together into the close-knit group which they finally established, and of the beginnings of the group activity which culminated in the games recorded, but unfortunately I have not the material for this. I can only state that, in the early part of the year in which I observed them, when their difficulties were at their height, all attempts at persuading them to sublimate their urges were unavailing, and that in the end it happened spontaneously, thus illustrating the truth of Anna Freud's (1948) remark that "the child cannot be forced to sublimate his instincts—he can only be offered appropriate opportunities at the right moment."

The masculine identification achieved by the boys was aided by the fact that they all had fathers who appeared to take a great interest in them, to talk to them and take them out; and that in addition Eddie and Roger had older brothers whom they hero-worshipped, and who also appeared willing to spend time with the little boys and to talk to them about masculine interests and things that were going on in the world.

SOCIAL ASPECTS OF SUBLIMATION: WORK AND PLAY

The extent to which, in their games, these boys were imitating activities, which to adults are work, is self-evident from the examples; but their own feeling that they were "working" was even more evident than has yet been indicated. If it was not clear what they were playing at from watching and listening to them, and I questioned them about it, they quite often, in the first instance, merely answered "Workmen"; and it was only after a further question that I elicited what type of workmen.² There was an amusing incident one day when Bobby and Roger were—for once—playing with a little girl. She was a very pretty little girl, not quite three, who had just started at Nursery School, and all the children made a great fuss of her; Bobby and Roger were stroking and patting her, and Bobby said to me in an awe-struck voice: "Look, she *likes* me, she *touches* me!" After a while the boys went off and started busily trying to pull up some stakes from the ground. "We have to get on with our odd work now," said Bobby sternly, as if feeling that enough time had been wasted on dalliance.

Here I would stress the fact that it was the *group* aspect of the boys' activities that enabled them to indulge in games which were so much akin to the work, sports and hobbies of the adult, and that enabled them, in their activities, to utilize several of the pregenital component impulses in one piece of activity, thus distinguishing their play in one important respect from that of younger children, who usually play alone, or with one grownup, or using other children as if they were inanimate objects. We might trace a parallel between primitive man, who works alone or in the family group, and modern civilized man, who works in groups of infinite variety in size and complexity. Here we are also again reminded of the oedipus complex and its relationship with sublimation, since it is only when the component impulses are beginning to come under genital primacy that group activity like this becomes possible.

But it would, of course, be erroneous to maintain that the children

² In the discussion referred to above, Miss Anna Freud drew a contrast between these children and a little boy in the Hampstead Nurseries, who used to wear a workman's cap, watch people working, and talk about the jobs he had been doing, but who did not actually carry out activities as these boys did.

were in fact 'working' One of the important distinctions between work and play, as Anna Freud (1945) has pointed out, is that work is governed by the reality principle and play by the pleasure principle Most grownups are compelled to work in order to gain the means of livelihood, and it is only a minority who enjoy their work so much that they do it for its own sake, even if not forced to do so by economic needs There is also in adults the feeling that it is a duty to work, to contribute to the well being of society But children of four years have their material needs attended to and are not forced to work These boys played the games they did because they enjoyed playing them for their own sake, because the games met their inner needs at their particular stage of development, and because their outer circumstances enabled them to deal with the inner needs in this particular way

SUMMARY

A description is given of a small group of boys observed in a Nursery School their difficulties in dealing with their instinctual needs and the sublimatory activities by which they overcame these difficulties Some theoretical questions arising from the concept of sublimation are briefly discussed and illustrated from the descriptive material

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CLINICAL NOTES ON AGGRESSION IN CHILDREN

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Freud's formulation in 1920 that aggressive trends are the expressions of a primary, independent and basic instinctual drive, coexistent with the libidinal drive, opened a new vista in clinical psychoanalysis. The theoretical implications of this formulation have been widely discussed, especially by Bibring (1941), Hartmann, Kris and Loewenstein (1949) and Anna Freud (1949a). With this theory Freud supplanted his earlier theory that the basis of aggressive trends is in the 'ego instincts'. Although the utilization of the newer concept in clinical reports has by this time become a common place event, the present study is offered as an effort at a more systematic approach to the clinical problems of aggression. It consists of a series of notes based on observations of children in the latency period and in adolescence, who were in residence in a placement institution.²

The psychoanalytic concept of aggression as a primary instinctual drive demands a careful distinction between two meanings of the word 'aggression,' one as an instinctual drive, the other as a description of an act or of behavior. Aggression as an instinctual drive is always unconscious, a force in the id, not recognized until derivatives that utilize its energies appear as acts, thoughts, emotions or symptoms. It is not surprising that only these derivatives occupy the attention of nonanalysts who do not consider unconscious factors, but the value of their descriptive studies should not be minimized.³ It is a different matter when a psychoanalyst writes, as does Franz Alexander in *Our Age of Unreason* (1942) in a discussion of aggressive behavior, 'It is an adaptive phenomenon, a means of survival, and it is of little interest to us whether it is a funda-

¹ From The Pleasantville Cottage School of the Jewish Child Care Association, Pleasantville, N. Y.

² This institution is described in detail in a paper by C. P. Oberndorf (1949).

³ See for instance, Dollard et al. (1939) and Mowrer and C. Kluckhohn (1944). These authors acknowledge their debt to Freud's early writings on aggression but do not accept his later formulations.

mental drive or not." It is precisely the purpose of this study to demonstrate the usefulness of the concept of aggression as a fundamental instinctual drive in the understanding of aggressive manifestations in children.⁴

Anna Freud (1949 a, b) has most clearly delineated the approach which I shall present in this paper. She has indicated that aggression may be studied: (a) as a quality of the pregenital sex manifestations, (b) as a function of the ego (the "frustration theory"), and (c) as the expression of the destructive instinctual impulse. In this study I follow Anna Freud's delineations with some modifications. The cases are grouped in three categories: (1) clinical manifestations of aggression in relation to ego development, (2) clinical manifestations of aggression as expressions of sadomasochistic relations, and (3) clinical manifestations of aggression as a reaction to frustration.

The first grouping will include cases with ego disturbances where the aggressive manifestations appear as irruptions of instinctual energies from the id, related to the ineffectual control by the weak or immature ego; the second grouping will include the manifestations of aggression in relation to the sexual (libidinal) drives and will concern also the stage of libidinal development of the child; the third grouping will include cases in which aggression appears essentially as a defensive function of the ego. It must not, however, be assumed that cases fall clearly into one or another grouping. Emotional deprivation that may be the basis of an ego disturbance, for instance, will at the same time be a frustration, and the aggressive responses in such a case have a multiple causation. Similarly a libidinal conflict may at different levels, preoedipal or oedipal, precipitate frustrating situations that bring out aggression as an ego defense. An immature ego with its inability to tolerate frustration will be characterized by a readiness to respond to a further environmental frustration by aggression. In any given case there will be an intermixture of these different expressions of aggression, and in this paper a case is presented in one grouping or another according to the predominant manifestations for the purpose of demonstration.

Aggression in a child is a complex phenomenon and the significance of an aggressive act cannot be determined by its overt manifestations alone. The increasing importance of ego psychology in psychoanalysis requires that in a clinical study instinctual manifestations be correlated

⁴ The theory of the "Life and Death Instincts" is a further development out of the theory of aggression as a primary instinctual drive. The former is a biological theory which does not concern us here, nor is it essential for the clinical application of the theory of the aggressive drive. See Bibring (1911), and Hartmann, Kris and Loewenstein (1917).

with ego and superego functions and with object relations.⁵ Genetic and dynamic factors must be considered to establish the stages of libidinal development, areas of conflict and characteristic defenses. In a given case the phenomenology must be described, the nature of the aggressive manifestations in terms of behavior and symptomatology. The aggression may present itself as destructive behavior which may be directed toward an object, animate or inanimate, or toward the self. Its aims as an instinctual drive may be destruction or mastery. Aggression may be manifested in various areas, especially in relation to the mother where the conflict may be a struggle over food, sphincter control or sexuality. Much of the information which is necessary for the evaluation of the aggressive manifestation can be obtained from a careful history and by direct observation. Much of the information must be obtained from the child directly in order to uncover the conscious and unconscious fantasies behind the overt manifestations.

I AGGRESSION IN RELATION TO EGO DEVELOPMENT

Aggression as an innate instinctual drive emanating from the id will, by its biological nature, seek constant discharge and gratification. The control of this aggressive drive for purposes of adaptation therefore requires the functioning of an ego and superego capable of mediating its demands with those of reality.⁶ From this it follows that aggressive behavior may be expected to be a regular concomitant of immature ego development or defective superego development, and further that it is normal for aggressive behavior to be prominent in the still immature child whose ego is in the process of development.

The modifications of the manifestations of the aggressive drives, like those of the libidinal drives, are subject to vicissitudes which are intimately bound up with the maturation of the ego functions especially the development of the defenses. These modifications are familiar to the analyst and are especially important where they serve as normal devices for the handling of aggression, particularly displacement, restriction of aims, fusion with libido and sublimation (Hartmann, Kris and Loewenstein, 1949). Modifications which tend to more pathological expression include projection, reaction formation and turning of aggression on the self. Of these the last will here receive special attention.

Hartmann, Kris and Loewenstein (1949) have brought out that turning of aggression on the self may be noted in two different forms. In one

⁵ The importance of studying the ego (and superego) in terms of the individual functions that comprise these structural subdivisions of the psyche has been especially emphasized by Hartmann (1950).

⁶ See especially Hartmann (1950) on this point.

it is an expression of normal development with a neutralization of the aggression and its internalization, a process leading to growth of the ego and superego; in the second the aggression is not neutralized but is turned against the self and becomes clinically manifest in self-destructive acts. The attack upon the self (the body) must in turn be differentiated from the attack upon the ego (a subdivision of psychic structure). Though both may appear as self-destructive acts the latter, which is more strictly related to masochism, is more complicated and implies a considerable degree of ego and superego development, as well as development of object relations. These considerations become clear when we remember that the body is always present—the ego must develop.⁷

Anna Freud (1949 a) has emphasized that in very early phases aggressive energy may find outlets on the child's own body in the form of head knocking, hair pulling and biting the self. Beata Rank (1949) also distinguishes the early diffuse motor discharge of the child with "fragmented ego" or in early stages of development from the more or less goal-directed aggressive and destructive behavior of the child with further development of ego and of object relations. Similarly with regard to aggression turned on the self, as ego and superego develop, the aggression turned on the self also becomes more purposeful, goal-directed and accompanied by evidences of anxiety and guilt. The importance of these observations lies in the clinical point that not all attacks upon the self should be interpreted as superego activity.

Hartmann, Kris and Loewenstein (1949) have indicated the need for further study on the problem of the internalization of aggression with and without neutralization, especially as it relates to ego and superego development. In either case the internalized energy may be used as cathexis of the superego and be the source of guilt feelings. The authors make the tentative assumption that "the capacity to neutralize large quantities of aggression may constitute one of the criteria of ego strength or of the high capacity of the ego for integration. Alternatively, the internalization of non neutralized aggressive energy in the ego may be the hallmark of a weak, or eventually of a masochistic, ego."

The interrelationships of instinctual activity and ego functioning is brought out by Anna Freud (1946) in the concept of the ego's "instinctual anxiety (dread of the strength of the instincts)." This inherent antagonism between ego and instincts leads to vigorous defensive efforts on the part of the ego when it is in danger of being overwhelmed by the instinctual drives. When the ego involved in such a disturbance of the balance

⁷ Here again one must keep in mind the complexities of the term "ego" (Hartmann, 1950). A discussion of the metapsychology of masochism is, however, beyond the scope of this paper.

between its strengths and those of the instinctual drives is immature or pathological, the available defenses will also be inadequate or pathological. The defense of turning the aggression on the self (the body) is especially to be noted under these circumstances.

In the cases to be described the attempt will be made to distinguish between the two forms of self attack, that of a direct attack upon the body when the ego is overwhelmed by the aggressive impulse, and that of an attack upon the ego by the superego. The following case has been chosen to illustrate aggression as a manifestation of severe ego disturbance.

*Case 1*⁸ The patient is a twelve year old boy who was born when his mother was nineteen. The father deserted the family before the birth of the child. The parents were in show business and the mother left the care of the child to others from his birth. At first he was with members of the family and at about the age of five months he was sent to the first of a series of private boarding homes. The child suffered on two scores: first, he never remained in any one boarding home long enough to form a continued relationship, and second, his mother continued to visit him irregularly and subjected him to an inconsistent relationship with her. This state of affairs continued until the boy was four and a half years old, when the mother took him to live with her and for the next three years the two were together. During this period there was a man in the picture, presumably the mother's lover, with whom the boy had some irregular contact. Details of the boy's early behavior are not available but by the time he came to live with his mother he already manifested severe aggressive conduct. He beat other children and also frequently got beaten up by bigger boys; he truanted from school; he was disobedient. He was destructive, breaking up things at home and at school. He was very hyperactive: set several fires and ran away several times. This was handled by the mother and the man who was acting as the stepfather by beatings and threats. The result was an increase of the aggressive behavior. During this period the child was exposed to overt neglect by his mother but at the same time he slept each night in the same bed with her and an aunt. When he was about eight years old he was sent to a psychiatric hospital and about this time his mother gave birth to a girl. No change in his behavior could be associated with the latter event. He was returned home from the hospital after about a year, but his behavior at home immediately resumed the former severe manifestations. He was then sent to another hospital for a short while, after which an attempt was made to place him in a school where he lasted only one day because of his marked aggression. By this time the rejection by the mother was undisguised. She did not visit the child and she sought placement which would relieve her of the burden of his care. He was placed in Pleasantville Cottage School at the age of nine.

⁸I wish to thank my colleagues at Pleasantville Cottage School: Drs. Alexander J. Friedman, Albert E. Goldberg and Edith Jurka for their co-operation in gathering the clinical data.

The outstanding clinical manifestations in this boy were his aggression and his poor ego functioning. He was destructive and demanding in his relations with the caseworkers. His activity in the therapeutic session with the psychiatrist for the most part took the form of aggressive behavior. A piece of clay was an object to be used as a weapon, to throw at some one. He climbed through the window, banged on the door, attacked any other child in the room. In the course of treatment he learned to displace his aggression onto inanimate objects, for example, he attacked a pillow with violence, till he fell exhausted from the effort. In his relations to the other children he was constantly in fights. He attacked without consideration of the effect upon him. If the child was smaller than he, he would of course be the winner. If the child was bigger there was a curious manifestation. He would attack the other boy and when the attack was returned he would let his hands fall and quietly take a beating. A tendency to get himself hurt was also noted in frequent accidents.

Evidences of disturbed ego functioning were the demand for immediate gratification, the inability to postpone gratification, disregard of the demands of reality (though no disturbance of reality testing), and poor work at school. There were minimum evidences of superego activity in this boy such as guilt, self-criticism, formation of ideals and moral demands. Anxiety appeared only as the response to an immediate external danger. Libidinal and reality factors play an obvious and important role in this case but for the purpose of the presentation only the factor of ego deviation has been emphasized.

The turning of aggression on the self was manifested in this boy in two ways—one by provoking attacks on himself, and second, by a tendency to get hurt. For example, with apparent disregard for realistic consequences he would get in the way of cars or climb to dangerous heights on the roofs of cottages. He suffered a series of fractures. The quality of this behavior as it impressed the examiner was its lack of goal directedness, its diffuse nature. The absence of guilt reactions, the purposelessness of the behavior suggested the activity of nonneutralized aggressive energy primarily directed against the self, and only partly against a weak masochistic ego. The aggression was without malice or hatred.

In evaluating this case the two factors of ego immaturity and aggression were constantly interrelated. The aggression can best be explained as the irruption of direct instinctual forces, poorly controlled by the immature ego. The ego deviation was clearly influenced by the disturbed mother-child relations in early infancy. That this early emotional deprivation was a frustrating experience and so also a factor in developing

a readiness for aggressive responses, is self evident but the boy's present aggressive behavior (including aggression turned on the self) was related to immediate frustrations to a minimal extent

This case is typical of many others in which aggressive manifestations were related to poor ego and superego development resulting from emotional deprivation in infancy (Beres and Obers, 1950) Separation from parents, especially the mother subjected these children to the lack of opportunities for adequate identification with parent figures This type of case has been described by many authors⁹

The factor of object relations which is closely involved with ego development requires equal consideration In this boy, object relations were on a level of transient identifications that paralleled his poor ego status Other cases showed distinctly the relation of variations in aggressive manifestations to different levels of ego development and object relations The following case may be compared to the one already described

Case II This eleven year old boy was born out of wedlock and at the age of three months was placed in an institution for infants where he remained until he was two and a half years old The mother surrendered the child when he was about one year old A series of foster home placements from the age of two and a half to nine were unsuccessful because of his aggressive behavior, truancy and fire setting At Pleasantville Cottage School his aggressive behavior included severe attacks upon other children and hostile attitudes toward adults, and in addition a series of self destructive acts such as jumping off the roofs of cottages, hitting his head on a wall squeezing his neck and putting a rope around his neck On one occasion he bit himself on the shoulder and began to scream The significance of this act is undetermined though the cottage mother who witnessed it looked upon it as a device to get attention Soon after placement in a foster home the boy's aggressive behavior became evident especially as stubbornness and destructiveness At the age of four he was sent to a psychiatric hospital for study where a diagnosis of 'Psychopathic Type of Personality' was made In a subsequent placement this boy was at first aggressive but after a younger child was sent away from the home his behavior improved and there was almost no evidence of his destructive activities In contrast to the first boy who at no time made any adjustment in a foster home, this boy developed what appeared on the surface a good relation to a foster family in this placement Unfortunately this home had to be given up because of illness of the foster mother His removal to a new foster home brought out a violent recurrence of aggression at home and at school A return to the original foster family after a few months resulted in a temporary diminution of the aggression but when his symptoms recurred he was referred to a psychiatric hospital for study A diagnosis of 'Psychopathic Personality' was again made and he was placed at Pleasantville

⁹ For an exhaustive summary and bibliography see J Bowlby (1951).

Cottage School at the age of nine. Recently an effort was made to return the boy again to the original foster home because he improved at Pleasantville but this failed after a few months because of the return of aggressive symptoms and in addition bizarre manifestations that suggest a schizoid process.

The interesting feature in this case is that this boy was capable of more adequate relations to adult persons than the previous child. However, his relations were labile, superficial, intense, but without warmth. His self-destructive acts were more directed and formed than those of the previous case. One got the impression here of more ego and superego formation. He spoke of the fairness of the restrictions placed upon him for his infractions. He made a slip of the tongue on one occasion, saying that here they don't punish you hard enough. There were in this boy, periods of good conformity. His school adjustment was better than that of the first boy. There was more evidence of an intrapsychic conflict. The biting of the self in a boy of this age without mental retardation is especially interesting as an expression of nonneutralized aggression turned on the body, though the full significance of the act is not clear.

In this case the evidences of ego deviation were specially noted in the inability to delay gratification and in the disregard of reality demands. The aggressive outbursts, attacks on others and himself, were often without apparent relation to external provocation. A chronic source of frustration was the boy's uncertain relations to the original foster family who gave him hope that he would be adopted by them but who never followed through by direct action. The foster home did, however, supply this boy with a more stable relationship than the previous boy had, and this was probably an important factor in the better ego development which he achieved. Because of the episodic character of the outbursts of aggression in this boy the examiner would more clearly get the impression of an ego overwhelmed by an irruption of instinctual aggressive energy. The attacks were more violent than in the previous case.

Another case in which ego disturbance and turning of aggression on the self are important factors is the following one, in which also evidences of superego functioning are more prominent than in the two previous cases.

Case III An eleven and a half year-old girl was placed in an institution for infants at the age of one and a half years when the father deserted the family. She remained in this institution until she was three. Subsequently the child was in foster homes until the age of five when she returned to the mother, who had remarried. The mother was killed in an auto accident when the girl was eight years old and she was sent to live with relatives. The maternal grandfather with whom the child was in close contact is a pervert, known to the police for his

sexual involvement with children. It is probable that there has been some direct sexual play between the child and her grandfather, if not actual coitus. She was a demanding clinging provocative child. She was aggressive, disobedient and impulsive. She attacked other children and on several occasions she attacked adult persons. One time after a minor provocation she threw down and began to beat a cottage mother, crying at the same time that she wanted to stop and could not do so. She had definite mood swings and depressive reactions. She would get hold of knives and hide them, threatening to kill herself or other children who provoked her. She had an obsessional wish to return to the spot where her mother was killed and to die in the same way. She expected an early death.

In this case the ego deviation appears in the form of impulsive behavior, and as in the other cases, a disregard of reality consequences and the inability to postpone gratification of her demands. Poor ego development was also manifested in her poor school work. But the aggression was more goal directed, usually in response to a frustration. The aggressive act was often immediate and impulsive but, in contrast to the first boy's behavior, was combined with expressions of malice and hatred. She planned acts of revenge. Her mood swings and depressive reactions had the quality, though transient, of a superego introjection. The identification with the dead mother was clear. This girl did not attack her body as did the two boys. The internalization of the aggressive energy already showed marked masochistic trends, guilt feelings and depressive reactions. It should be noted that this girl was with her mother in infancy for a longer period than the two boys and this may be a factor in her more developed ego and superego structure. There was also considerable libidinal contact with the grandfather. In this case the aggressive responses were more directly related to external frustrations, but the quality of the responses, especially their uncontrolled nature, was best understood in terms of the ego deviation. The more highly developed object relations were reflected in the content of the aggressive acts which were more definitely directed to persons in libidinal relations to her and in the masochistic manifestations, the depressive moods and death wishes.

In the three cases so far presented there are varying degrees of ego disturbance. In each case there was a disturbed mother-child relation in early infancy with emotional deprivation. However, in their present manifestations they show different degrees of object relations, ego functioning, and superego activity. The manifestations of aggression may in all cases take the form of attacks upon others, destructiveness, and attacks upon the self, but the evaluation of the level of ego and superego functioning gives to each case its distinctive significance. The haphazard undi-

rected reactions of the first boy; the episodic outbursts of aggressive drives in the second boy; the masochistic, structured conflict in the girl.¹⁰

II. AGGRESSION AND LIBIDO

A basic postulation regarding the interrelation of the primary instinctual impulses of aggression and libido is that in their overt manifestations, whether normal or pathological, they appear in various states of fusion, with the resultant richness and variety of human behavior. Specific aspects of the libidinal forces in each instance, such as the predominant level of instinctual functioning and the nature of object relations will affect the aggressive act. Thus in combination with oral drives, aggression is manifested in the insatiable and demanding character of the love, and the wish to merge with or become one with the love object; with anal drives, aggression appears in the clinging possessive nature of the love or the sadistic play with toys or animals; with phallic drives, it appears as aggressive exhibitionism and a competitive dominating attitude toward the love object. Anna Freud (1949 b) has pointed out that in the pregenital stages it is not hate but aggressive love which threatens to destroy its object. Ambivalence is best understood as the overt expression of unsatisfactory fusion of libido and aggression. Fusion of instinctual drives assumes special importance because fusion of aggression with libido is one of the most important means of modifying the destructive effects of the aggressive impulse in the child. (Hartmann, Kris and Loewenstein, 1949; Anna Freud, 1949 a, b; S. Freud, 1919).

At this point my argument leads back again to the ego since fusion of instinctual drives is intimately related to the development of the ego. It is only as the ego develops and distinguishes between ego and nonego that objects are recognized and cathected with libido and aggressive

¹⁰ An important manifestation of ego deviation is its relation to schizophrenia, and the prominence of aggressive behavior in schizophrenia is a common observation. Extreme aggression in children is sometimes taken as a diagnostic criterion of schizophrenia. In my opinion this is a reversal of the basic relation. I have not found the degree or nature of the aggressive reaction in a child to be pathognomonic of any clinical entity. The diagnosis of schizophrenia or of a schizophrenic state, especially in children, requires a more total approach, including especially the evaluation of the ego functions. Some of the cases included in this paper showed marked schizoid features but further study of this important question must be postponed at this time. A detailed investigation of schizophrenic manifestations in the children at Pleasantville Cottage School is now in progress.

Organic disturbance of the central nervous system with the attendant effects on motor and intellectual development will also influence the functioning of the ego, and so, the manifestations of aggression. According to the views here presented the aggression noted in such cases is secondary to the ego deviations resulting from the organic pathology.

energy Hartmann, Kris and Loewenstein (1949) note that through a simultaneous cathexis of the object with libido the aims of aggression are modified. They point out the interdependence of the differentiation of psychic structure (which includes ego development) and the relation of the self to external objects. Kris (1950) suggests that "we might assume that the more satisfactory the object relation is the higher we are to estimate the successful neutralization of that energy which by identification becomes available to the ego—the 'better,' i.e., the more completely, aggressive and libidinal energies are fused in the cathexis of the object, the higher the chances of a successful neutralization."

It follows, then, that in the consideration of the relation of the aggressive drives to libido in a child, the study of the ego status and object relations must be pursued with equal intensity. In the cases that were described in the preceding section this constant interaction of these various factors was emphasized, as it will be also in this section.

The cases chosen here show as their most striking manifestation the interaction of aggressive and libidinal drives. In the cases in this group ego development has progressed to a greater degree and conflicts between ego and id, that is, psychoneurotic manifestations, appear with more prominence. Such manifestations are sufficiently well known and it is not necessary to describe them in detail. There would be included anxieties, phobias, compulsions, masturbation activities and masturbation fantasies, tendencies to act out conflicts in the family, and by displacement in the school or institution.¹¹

Aggression and Family Relations

When aggression becomes part of the child's conflict in relation to the family, it assumes many different forms. It colors the manifestations of the oedipal conflict. It may become the reaction to, and part of, a sibling rivalry.

Case IV An example is a twelve-year-old girl of superior intelligence who had to be placed because of her aggressive behavior and her conflict with her mother. Rivalry with a brother four years younger was marked. Her symptoms included headache, stomachache, food fads, nail biting, fear of the dark and of closed doors. Her behavior at Pleasantville Cottage School was characterized by an immediate displacement of her conflict to mother persons about her. She divided her relationships to these mother persons into a series of good and bad mothers. Toward the bad mother person she would manifest provocative and hostile attitudes. Characteristically, in the course of time her ambival-

¹¹ For the basic relationship of behavior disorders and libidinal conflicts in children see especially Anna Freud (1949c).

ence manifested itself in changing the roles of a given object from good to bad or vice versa. The particular nature of her aggressive behavior was a tendency to tease and to instigate discontent among other children and to play practical jokes. She was argumentative and a quibbler. When her relations assumed a positive character they were intensely passionate. Her projective defense was noted in her criticism of a cottage mother whom she called "Loony," describing the latter in terms applicable to herself because she acts phoney, loves one minute and is critical the next. This child was overtly rejected by her mother who favored the younger brother. The mother's mother died about the time the child was born, a detail emphasized by the mother. The mother was herself a neurotic woman and many of the child's complaints about her were on a realistic basis. The father was a passive and self-effacing man whose work took him out of the home several days each week.

The libidinal components of this girl's behavior appeared especially in her transference responses in therapy as well as in her activities in the cottage and school. Her aggressive provocativeness and conflict were always in association with elements of love. The preoccupation with adult female figures suggested a homosexual conflict. This girl lived with her family throughout her life until her placement and the indication for placement was, in fact, the conflict with the mother.

Sadomasochistic Mother-Son Relationship

An impressive observation in the area of the interrelations of aggression and libido was a constellation consisting of a marked overt conflict between mother and son which in many cases took the form of physical attack upon each other, with at the same time a close dependent relation and sexually colored activities such as sleeping together, the mother bathing the boy or helping him with dressing or toilet procedures. In these cases the boy was usually an only child and if there were other children the conflict was usually not evident in the mother's relations to these other children. The mother was characteristically the dominating parent, a woman of superior intelligence with obvious ambitious strivings, and often, undisguised masculine wishes which were frustrated both in her own life experiences and in the failures of her husband. The disappointment in the husband was often transferred to the attitude toward the son. The mother would present a façade of charm and agreeableness but quickly gave evidence of her underlying aggressive conflicts in her attitudes toward social worker or psychiatrist. These were often evidences of obsessional psychoneurosis or obsessional character. The father was usually in the background and a failure in his chosen work or profession. He followed along at his wife's command and might even be the

instrument for punishment of the boy doing this at the behest of the mother

Case V Such a case is that of a boy who was ten years old when he was placed. The problem began here as the sudden refusal to go to school at the age of seven and a half. The mother reports that prior to this there had been no difficulties with the child (a statement which is to be doubted). Following an infection described as glandular fever during which the boy was home under his mother's constant care for two months he returned to school for a week. At that time he defecated in his pants while at school and instead of returning to school the next day he wandered about the streets. His mother did not know that he had truanted. When she learned this from a neighbor she met the situation by beating the child without offering him an opportunity to explain what had happened. The boy did not fight back until his mother began to destroy his possessions especially a collection of comic books which were to him very important. When his mother in her fury began to tear up his comic books he attacked her and from then there began a series of mutual attacks in which both suffered considerable physical injury. These attacks alternated with tender scenes in which she embraced the child promising him all sorts of gifts if he would behave. Along with the conflict the two were inseparable and for a while the child did go to school as long as the mother remained in the classroom or on the school grounds. The boy was an only child who was born after a prolonged labor. He had a congenital anomaly of the tear ducts which required surgical intervention at the age of two. He also had a congenital malformation of both thumbs which was treated by the application of splints for two years. He was breast fed for four months and weaned suddenly an act on which the mother explained by saying "I didn't like breast feeding him. I resented it. I'm not just a cow." She began to toilet train him at the age of three months and states that he was completely trained at the age of nine months. He always slept in the parents' bedroom. The mother herself had been forced to quit school early and the disappointment about this was a factor in her severe reaction to her son's truancy. In her interviews with one of our staff psychiatrists it became evident that she was an extremely aggressive woman who felt proud of her mastery over her husband. The father was a quiet man, a mechanic whose role in this picture was to accept placidly his wife's aggression and to carry out his wife's requests to beat the child. The mother on a number of occasions attacked her husband physically but he retaliated rarely. One of her ways of taunting her husband was to throw perfume on him.

In this boy the close connection between the aggression and the disturbed libidinal relations to the mother was clearly evident. Physical attacks were directed only toward the mother. With other persons he was polite even obsequious. His aggression appeared most prominently in a quiet refusal to co-operate in the treatment with the psychiatrist.

In this case as well as in others of the same nature the mother's up-

bringing of the child, especially toilet training, was rigid and forced. The mothers were inconsistent and subjected their sons to confusing experiences of rejection and overindulgence, the latter often with overt sexual content. The children's aggressive behavior both toward the parents and outside of the family was mixed with sadistic or masochistic components. The aggression usually began in conflict with the mothers but in the course of time was displaced to other persons. In one case the sadistic character of the relations to the mother was demonstrated in the latter's report that on several occasions after her husband had left for work, she was awakened in the morning by her son who had climbed into her bed on top of her in a sexual embrace, but at the same time with his hands about her neck, choking her.

These cases differ from those described in the first section of this paper because of the greater prominence of the libidinal factors. This difference may be explained in part by the fact that the children described here were brought up within their own families, whereas all the cases in the previous section were separated from their mothers in infancy.

These cases are particularly interesting in view of the significance of the clinical picture to the problems of placement. The indication for placement was in each one of these cases the conflict between mother and child. This is in contrast to placement that becomes necessary for external causes such as death of a parent or separation of parents. The conflict would come to the attention of a social agency or school either because the mother brought her complaints to the social agency or because the child's aggressive behavior was displaced to the school environment. The social agency would attempt to work with mother and child and would then recommend separation of mother and child after a period of time when it was evident that no progress was being made. As one would expect, this often created a new problem because the demand for reunion by the mother and child would become immediately evident. This sometimes took the form of the child's running away from placement within the first few days; or else the mother might descend upon the institution and take the child home with her, rationalizing her act by some superficial complaint. At times there was a surface acceptance of the separation, but that this was a reaction formation would become evident in working with the child as well as with the mother. The importance of these considerations leads to the question of the therapeutic approach to these cases. While this would take us beyond the limits of the present paper, it is important to note here that the best use of the placement experience requires a carefully planned approach including treatment of the parents.

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Aggression and Libido Interaction with Ego Deviation

The following case was chosen to illustrate severe aggressive behavior in a child with immature ego development ('fragmented ego' of Rank), with, at the same time marked libidinal manifestations and signs of early superego formation

Case VI This is a girl eight years old, who was born out of wedlock. Her mother a psychotic woman saw the child only once a month for the first year during their stay in an institution and rarely during the following year. She placed the child immediately after her release from the institution so that the child has had no contact with her mother since she was two years old. She was in a series of foster homes up to the age of seven but failed to make a satisfactory adjustment although each placement began well and some lasted up to a year and a half. Her symptoms consisted of destructiveness and hyperactivity. Her behavior was particularly characterized by impetuosity and impulsiveness. This was demonstrated in the therapeutic setting where she jumped from one activity to another. She could not keep her hands off any object which attracted her attention. She had an obsessional interest in keys and given a key would have to try it out on every door that she could get to. She had a limited tolerance for frustration. She would accept no interference with her wishes. In treatment for instance she would refuse to leave the room after an interview. If forced to do so she reacted with a violent outburst of aggression kicking at the psychiatrist or biting. At the same time she was clinging and wistful. She would say "Can you help me? I want you to help me. I am not happy." She gave the impression of being intensely attached but these attachments were transient, superficial and uncertain. In the history it was reported that the different foster mothers were all attracted by this child and wanted to keep her but her difficult behavior made this impossible.

The problem in this complicated case would be to point out the connection between the aggression, the ego deviation, the object relations, and the libidinal factors. The disturbances of ego development are evident in her inability to tolerate frustration and her limited awareness of reality restrictions. Her poorly organized motor activities and her poor work at school (despite normal intelligence) were further evidence of disturbed ego function. The object relations, as one would expect with poor ego development, were in the nature of superficial identifications; however, they were very intense, and the strength of her efforts to establish relations was striking. This girl like the children described in the first section of this paper, was separated from her mother in her infancy, but it may be that an important factor in the difference in her object relations was that at the time of separation she was sent to a foster home and not, as some of the other children, to an institution. The first boy (Case I) also was not placed in an institution but of all the children, his early

experiences were the most inconsistent as his mother took him from one home to another. The libidinal components in this girl appear in her strong efforts to establish object relations. The pregenital aspects of her object relations were evident in her fantasies. In her work with the therapist she not only was given to outbursts of aggression, kicking and biting when frustrated, but in her play invited the therapist to beat her. One of her favorite phrases was that she would "beat the shit out of" physician, cottage parent, social worker, or whoever frustrated her. In her play she set up a scene asking the therapist to threaten to beat her with a strap. When this was done she would break out with a loud cry "I'll be good, I'll be good, I promise!" When she went to the toilet she would ask her therapist (a woman) in a seductive way to "wipe" her, an act with which she had no actual difficulty. She told her own version of the Little Red Riding Hood story, with intense excitement, making of it a fantasy of oral aggression. In her version Little Red Riding Hood's mother wishes that both the grandmother and the child be eaten by the wolf. The woodsman owns the wolf and also wishes them both to be eaten. The undoing of the actual story, when the grandmother is taken out of the wolf's stomach was minimized by the child. Hints of early superego formation were evident. She would "Swear by God" that she would not commit this or that act. She said that if one swore to keep a promise that one had to keep it because if not, "God would give you a sin." She then explained that a "sin is a sickness," but a "little sickness which you can get all over any place" and illustrated by pointing to the lower portion of her abdomen.

In writing of children, such as this girl, who develop without the experience of relationship to parents Anna Freud (1949 a) states that the pathological factor is not to be found in the aggressive tendencies themselves, but in the lack of fusion between them and the libidinal (erotic) urges. In this child the lack of fusion is evident in the strong ambivalent responses, varying in their expressions from moment to moment. An interesting feature of this case is the development, in the absence of contact with parents, of beating fantasies which take the form of the acting out of the second phase described by Freud (1919), in which the child is himself or herself being beaten, and which is ordinarily the unconscious phase, expressing the masochistic wish to be beaten by the father. There were also other fantasies relating to familial situations. The sadism and masochism which appear here in their earliest forms parallel the early evidences of ego development, object relations, and superego formation.

Psychoneurotic Defenses

In cases where the conflict around aggression formed part of a psy-

choneurosis, defense manifestations often took over the center of the stage. Reaction formation, denial and repression were the most prominent defense mechanisms.

Case VII This is illustrated by the case of an eleven year-old boy who was very passive, shy, overpolite and obedient but who revealed under therapy a severe obsessive worry about the health of his parents, which was partly realistic because both did have cardiac disease. He had symptoms of somatic nature, including headache and vomiting. He suffered from nightmares. He presented as a peculiar symptom the complaint that he did not like the perfume which his mother used. Under treatment the underlying aggressive impulses became evident under the guise of irony and stubbornness. He revealed a strong ambivalent attitude toward his parents, especially the mother. His Thematic Apperception test brought out fantasies of his mother and an older sister as witches.

The important clinical consideration in cases of this type is to recognize, behind the defenses, the underlying conflict around aggression. This is often not difficult but the strength of the defenses, especially denial, in many cases makes the therapeutic problem not an easy one. Preoccupation with dirt, sometimes manifested in an interest in animals, will reveal anal fixations. In these cases also, the periodic outburst of an aggressive act was regularly observed. In one case such a quiet, conforming, well-mannered boy almost strangled another child in a sudden attack with very little overt provocation. Under treatment these children usually became more aggressive as their defenses were broken down.

Aggression and Homosexuality

An important clinical manifestation of aggression evidenced in our cases was the relation of the aggression to conflicts around feminine identification and homosexuality. Nunberg (1938) has brought out that the aim of the homosexual represents a compromise between aggressive and libidinal impulses. In some of the cases reported here the aggression was related to sadistic object relations associated with homosexual fantasies and overt homosexual acts. The aggression might serve as a denial of passive feminine tendencies. The following case demonstrates aggressive behavior in relation to a homosexual conflict.

Case VIII A twelve-year-old boy was placed at Pleasantville Cottage School because his mother, a psychotic woman, could not care for him. The family had escaped from Nazi Germany to another country when the boy was one year old. In the subsequent years the boy was exposed to many traumatic experiences including the mother's first psychotic episode when he was nine, which included acting out of prostitution in his presence. During her hospitalization the boy lived with the father, a cold, harsh, intellectual man. The father deserted the

family and the boy returned to his mother. Even in his earlier years, at about the age of eight, he was described as withdrawn, given to intellectualizing and subject to fears, especially of being attacked. In this country when the boy lived with his mother, he was in constant conflict with her, taunting her about her mental illness, masturbating in front of her, and attacking her physically. At Pleasantville Cottage School the boy developed increasing anxiety about being attacked by boys and men. He provoked beatings by bigger boys. His fear of attack assumed proportions bordering on paranoid delusions. He centered his thoughts around two boys whom he accused of making homosexual advances to him. He developed obsessive thoughts of killing these boys and stole a meat cleaver from the kitchen with which he made an abortive attack on one of the boys, an act that forced his referral to a psychiatric hospital. He was in his behavior passive and submissive, calling these boys Master, and doing chores for them. He acted out a hanging scene with another boy, tying a tie around the latter's neck and almost choking him, an act that was stopped by the fortunate appearance of a cottage parent. He himself begged to be hospitalized, expressing consciously his fear that he would be unable to control his murderous impulse. He was sent to a state hospital where his mother was already a patient. At this time he was fourteen years old.

This case is similar to those seen in adult patients. The aggression was clearly directed toward persons who were also homosexual love objects. In his productions there was suggestive evidence that he identified the homosexual object not only with the strong father but also with the phallic mother. An important clinical observation was the ego's fear of the underlying aggressive impulse expressed in the wish to be hospitalized. There were clearly defined schizoid manifestations in this boy, but reality testing was preserved.

III AGGRESSION AS AN EGO FUNCTION: REACTION TO FRUSTRATION

There is no conflict between the concept of aggression presented in this paper and the school of thought which looks upon aggression as a reaction to frustration, if one recognizes that the latter is only one of the several different expressions of the aggressive impulse that may be observed. Actually, as has been already noted, both are theories developed by Freud at different times, the broader theory of aggression as a basic instinctual impulse replacing the more limited theory. Aggression as a reaction to frustration may be understood as the utilization by the ego of the energy of the instinctual impulse in its normal adaptive response to a frustrating stimulus from either external or internal sources. But it is the conclusion from this study that where aggression forms a prominent part of the clinical picture, this manifestation of aggression, namely, the response to frustration, is of secondary importance. It would be clinically

incorrect to assume that an aggressive child is consistently reacting to external frustrations and to exclude the consideration of inner factors such as have already been discussed, namely, ego disturbances and libidinal factors¹²

Normal development of the child carries with it unavoidable restraints and frustrations which vary in different cultures. As Greenacre (1944) has demonstrated, the psychological effect of restraint on the child is determined by several factors especially the conscious and unconscious attitudes of the restraining person. It becomes important in evaluating the significance of frustration to examine carefully parental attitudes and environmental phenomena which influence the child's responses.

Frustration may appear as emotional deprivation of lifelong duration, as repeated frustrating acts on the part of persons about the child, or by frustrating limitations imposed by external reality. In any given child a mixture of all forms is always to be noted. Extreme emotional deprivation in infancy by separation from its mother is not only traumatic in terms of its effect upon ego development but it is also a frustrating experience which may set a pattern for the outbursts of aggression in such a deprived child when his demands are not immediately gratified in the later course of his life's experience. Counteraggression on the part of the parents or other persons responsible for the care of the child will also serve to increase aggressive manifestations in a child basically conditioned by ego disturbances or sadomasochistic conflicts.

Evidences of aggression as a reaction to frustration can be demonstrated in all the eight cases presented. Because these are children separated from their parents, they have all suffered at least the frustration of emotional deprivation that follows such separation. In some of the cases this separation goes back to early infancy. In other cases the frustration is of a more direct libidinal nature as sudden weaning, severe toilet training or the birth of a sibling. Several children were beaten on the buttocks in an effort to cure enuresis. One child had his face smeared with feces because he soiled. The use of restraint was noted in several cases.

The factor of frustration is sometimes so dramatic that it can be a pitfall in the clinical evaluation of a case, because the over identification with the child may arouse reactions in the therapist that interfere with his ability to examine other facets of the child's total picture. It is difficult for an examiner to be objective for instance, when the history reveals that a mother punishes a boy who wears glasses after an operation for congenital cataracts by taking away his glasses and rendering him

¹²S. Nachi (1948) centers his paper around the "notion of aggression as a consequence of frustration."

blind and helpless. But it is nevertheless essential to recognize that the boy, despite the extreme external frustrations, has a severe inner conflict and disturbances of his ego and superego, as well as in his object relations. It is the central thesis of this paper that in the evaluation of the aggressive manifestations, one cannot in a given case isolate the factor of frustration from the other factors, ego disturbance and relation to libido.

Aggression as a response to frustration has been widely discussed in the literature and it is not necessary to present it in greater detail here.¹³

IV. THERAPEUTIC IMPLICATIONS

The value of the theoretical postulations considered in this paper is particularly evident when one turns to questions of therapy. The indications for therapy correspond closely to the clinical divisions outlined above. Aggression must be treated (1) by efforts directed toward promotion of ego development, (2) by therapy of sadomasochistic disturbances, and (3) by the minimization of external factors which promote frustration.

In the cases where the aggression is predominately the manifestation of a disturbed ego development, the therapeutic indication must focus on this area. Of course in dealing with any child, the problem of ego development must always be kept in the foreground. The principles of such treatment have been discussed by many authors¹⁴ and include such measures as afford the child the opportunities for satisfactory relationships with adult persons, with whom identifications may be established to make up for the lacunae of his earlier life experiences. These measures apply with equal importance to the treatment of children with so-called schizophrenic manifestations.

In this phase of treatment the direct activity of the person or persons with whom the child is living may be more important than the direct therapy of the psychiatrist. The psychiatrist's function is often limited to that of interpreting the child's behavior to others concerned with the child. At Pleasantville Cottage School it is part of the plan to search out some person to whom the child becomes attached, such as a cottage parent, activities worker, farm worker or teacher, and then to strengthen this attachment with whatever practical means are available.

The normal maturational processes come into play here. These go on, even without direct treatment, and play an important role in the child's ability to adapt and to control his insinstantial impulses. Conflict-free,

¹³ See for example Edith Buxbaum (1947) and Paul Schilder (1942).

¹⁴ See especially studies by Beata Rank on the treatment of young children with atypical development, such as her paper with Dorothy Macnaughton (1950).

autonomous ego functions are of special significance (Hartmann, 1939) Kris (1951) has said, 'The self healing qualities of further development are little known'¹⁵ The role of the therapist must here be to foster the maturational processes and to remove conditions that may hinder them From this it becomes clear how important to child psychiatry and psychoanalysis is the increasing knowledge of early development

The second factor in the treatment of aggression that is, the treatment of the sadomasochistic relationship merges with the treatment of the ego deviation It involves the effort to promote fusion of the aggressive with the libidinal impulse Anna Freud (1949 a) says,

Where it is possible to help the child's arrested or otherwise disturbed libidinal impulses to become more normal the fusion between erotic and destructive impulses will follow automatically and aggression will be brought under the beneficent influences of the erotic urges

In this phase of treatment direct therapy of the child, psychotherapy or psychoanalysis becomes more important, and involves the consideration of the various psychoneurotic manifestations in the child In these cases object relations may be developed to a considerable degree and the treatment aims especially to resolve the ambivalent relations

The consideration of aggression as a response to frustration leads directly to the utilization of techniques, which permit the education of parents or other persons dealing with the child to avoid such measures as would provoke aggression on the part of the child This does not mean the elimination of restraint, but rather the application of appropriate restraints in terms of reality demands and the child's need for free growth and development¹⁶

It is not the aim of therapy to eliminate aggression as a manifestation of the child's behavior, nor indeed would this be possible were it attempted It is the aim to recognize the place of aggression in a child's normal development both as a normal instinctual impulse and a normal expression of ego function, and to permit the child to utilize this basic impulse in terms of a sublimated drive which is goal directed, ego-syntonic and reality-syntonic (Hartmann, 1939) Beata Rank (1949) has also emphasized this point in her studies on aggression It is the destructive element of aggression, as she says, which the therapist aims to modify

When one separates aggression as an instinctual impulse from its overt manifestations one can avoid the confusion so often noted in clinical papers on aggression Aggression as an instinctual impulse may be utilized by the ego in its adaptive efforts or as a means of defense The

¹⁵ Anna Freud (1945) also stresses this point

¹⁶ On this point see Kris (1948)

aggressive act may then be a normal adaptive measure. It may be utilized for purposes of destruction which from a social point of view may or may not be adaptive. In more complicated object relations it may manifest itself as hostility or hatred.

The most spectacular therapeutic results in the treatment of an aggressive child follow the removal of external frustrations, when the parental attitudes are modified or the child is removed from a frustrating environment to a more permissive one. For this reason, even in cases where the pathology of ego disturbance or sadomasochistic conflict is profound, striking therapeutic results are obtained by efforts directed toward the minimization of frustration. These responses, however, carry the child only a short distance on the road to adjustment and normal development, and unless further effort is directed toward the treatment of the ego problems and the libidinal conflicts, the results remain uncertain and tentative. The striking and often immediate response should not lead to an undervaluation of the other factors involved. It is the author's conclusion from this study that in considering aggression in children, it is these other factors, the ego disturbances and unsatisfactory fusion with libido, that are of greater importance in the total picture.

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ON TEASING AND BEING TEASED: AND THE PROBLEM OF "MORAL MASOCHISM"¹

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I INTRODUCTION

As the science of psychoanalysis grows, the necessity for trying to 'place' various highly organized pieces of clinically observed behavior within a coherent theory of psychological organization is sharpened. It is strange that although the early history of psychoanalysis is replete with instances of metapsychological discussion of complex clinical material, the more recent trend has been to offer, on the one hand, theoretical papers which are sparing of empirical illustration and, on the other, clinical papers which stick rather closely to naturalistic observation. It is hard to know what this means. It could signify that our science has matured to the point that the logical development of a theoretical argument no longer needs direct support from the treatment room or the experiment or, as I am more inclined to suspect, it means that a new and extremely difficult task is being posed by the rapid expansion of various modifications of psychoanalysis as a treatment method. This has provided an unprecedented variety and richness of direct experience, particularly with regard to ego functioning without a parallel development of theory. Perhaps the absence of unequivocally stated resolutions of various historical controversies on theoretical issues forces the clinical writer, who is usually not a theoretician himself, to shy away from the effort of finding a 'clear' place for his experiences even within the existing theoretical structure which is only beginning to take systematic form. Frequently his attempts in this direction confuse the observable behavior with the inferred unconscious operations and their corresponding metapsychological abstractions. This is particularly true when *the behavior under discussion is a complex configuration resulting from the interplay of (1) primitive unconscious drives with (2) defensive processes and (3) adaptive implementations*.

¹ This study was made possible by the Austen Riggs Foundation and by the U. S. Public Health Service.

These introductory remarks are intended to convey the frame of reference in which selected observations from the treatment of an adolescent girl will be presented. I will discuss the developmental history of this patient's role as "teasee," then the decompensation which temporarily altered the outer form of the organized configurations or, loosely speaking, the "character traits" which compose this role, and finally the subsequent reconstitution of a functioning equilibrium. With the help of this clinical material, I will try to sketch the psychology of the "teasee" with special reference to its place in the theory of "psychic" or "moral" masochism, and with regard to the id, ego, and superego aspects of the problem.

I will try to demonstrate the continuity and quasi stability of personality organization which seems to be maintained in spite of monumental shifts of psychic energy, and to set forth the general proposition that this continuity represents the unique configuration of the individual personality which is a persisting point of anchorage amidst the actually constant shifts of the balance of psychic forces, such shifts issuing in smaller "subconfigurations," some with the relative durability of character traits, others with the transient quality of passing moods.

To return to our selected illustration—the "subconfiguration" of teasing and being teased. The dictionary definition reflects the looseness and ambiguity of popular use of the verb "to tease." While the accent is placed on the hostile, destructive component, accepted definition includes the more benevolent dimensions of affection and humor.² Literally, "to tease" means "to shred finely, to disentangle, to tear in pieces," but more broadly, Webster tells us, "to vex, harass, or irritate by petty requests, or by jest or raillery." Yet another possible definition is the "awakening of expectation and then its frustration," the extreme of which is "to tantalize."

Egress from the dilemma of trying to comprehend a word which ranges in the dictionary from "tearing in pieces" to "raillery" is provided by the hypothesis that genuine teasing may be a highly organized human activity which occupies a peculiarly poised mid position with regard to various psychic functions. Teasing seems to stand somewhere between aggression and love, but is modulated by various processes—on the highest level by the adaptive, creative ego product, humor, as well as by simple and complex defensive processes which will be explored later. When the behavior loses this precariously poised middle position, it may proceed to pointed wit or become clearly hostile as in the derivative forms of ridicule, mockery, derision, or tantalizing, or it may "graduate" into the

² For example, the German proverb "Was sich liebt das neckt sich" ("Those who love each other tease each other.")

socially adaptive behavior of humorous banter, relatively free of barbs³ Conversely, the middle position of "teasee" may be abandoned for a variety of behaviors ranging from the masochistic provocation of an actual attack to what Annie Reich (1949) has called the 'particularly labile sublimation of a comic performance where the person becomes the one who is laughed at but who retains control of the situation by deliberately providing entertainment at his own expense

Inasmuch as there is to my knowledge only one significant psychoanalytic discussion (Sperling 1951) which labels itself specifically as relating to our topic, I have added to personal clinical experience reports of clinical observations which though described in the literature under various headings seem directly related to our general problem

II CLINICAL REPORT

Allerton W so named by her wealthy snobbish mother who had expected her to be a boy was an attractive though rather obese girl when she came for treatment at the age of fifteen She had been withdrawn from a fashionable boarding school after a series of frantic letters describing her abject misery over being chronically mistreated at school

From the moment she arrived at the sanitarium she became the court clown of the patient group with a rich repertoire of comic performance usually with herself as the presumed target of the joke She told her examining physician⁴ with utmost weariness and timidity I guess I keep them in stitches With him on the other hand as with other members of the staff her manner was dramatically different She scarcely spoke except to answer questions in a monosyllable maintained an unyieldingly wide eyed expression of please-don't hurt me and would regularly spring to her feet like a jack in the box in a caricature of deference if the examiner had occasion to rise during the interview Gradually her own therapist and to some degree other staff members began to tease her gently to be sure but teasing nonetheless It was as if everyone felt in her unprovoked look of terror and pleading an unjustified accusation of evil intent

³ This formulation is in important aspects similar to that arrived at independently by Sperling (1951) in his paper He says "teasing occupies some mid position of meaningfulness between the bi polarities of pulling towards-drawing back pain pleasure hostile friendly serious playful destructive constructive antagonistic-co-operative and willing reluctant." Perhaps the most important difference between this and the present formulation is that Sperling restricts himself in this definition to a description of what might be called "ego attitudes" themselves resultants of a variety of drives and counterforces He goes on however to discuss some of the latter vectors in the body of his paper giving greatest emphasis to the ambivalent expression of "instinctual drives" with many important hints regarding the role of defensive and adaptive ego functions in teasing behavior All this remains however implicit without a theoretical statement of the interrelations of these functions

⁴ Acknowledgment is due Dr Stuart C. Miller on whose careful record the early part of this report is based.

and an undefined implicit demand. On one occasion her first therapist (later replaced by the writer because of his illness) was sufficiently provoked by this manner to say "Did you notice all the heads stuck on spikes as you came up the stairs? Those are of my previous victims." While this was all in 'good fun' and appreciated as such by the patient, the translation of this jest seemed to be 'You behave as if I am such a bloodthirsty monster by your caricature of terror that I might be expected to have decapitated my previous patients. If you make so hostile an accusation, I will punish you by replying Yes, I am just such a monster, and your head will be next.'⁵

On most other occasions, during the period of this extremely difficult history taking the examiner seems to have met Allerton's exaggerated cowering with active reassurances and innumerable questions. It is quite clear that while he found her a lovable youngster, he felt in her attitude an overwhelming demand which he tried to satisfy in part, until her caricature of terror would bring forth from him a teasing joke such as that describing his previous "victims".

That this way of relating to 'grownups' had begun very early in Allerton's childhood slowly became evident from a piecing together of her fragmentary responses with the more articulate recollections of her parents. Her mother stated quite frankly that she had begun to dislike Allerton consciously when the latter was no more than four or five and had little doubt that she had chronically been unable to give her any kind of steady nurturance, although at this time she was a favorite of family friends who enjoyed her charming witty 'acts'. She was chronically afraid of her impresario father who constantly boasted of his effective intimidations of successful concert artists. Both parents recalled a warning from the pediatrician that Allerton's immense need for attention will get her into trouble.

With her mother however, Allerton was not good humoredly amusing. She was desperately ingratiating and oversolicitous from a very early age, pinning painfully gathered nosegays on her mother's pillow with extravagantly affectionate declarations of love, and later, when she could write, long notes in praise of her mother attached to numerous and lavish gifts. Her mother describes her as 'fawning' and says "all this giving began to pall on me." For the most part Allerton was extremely compliant to requests except for an occasional burst of iron stubbornness during which her parents would feel she was completely inaccessible. She would often hide her food and refuse to tell where. On occasions where some stand of hers was challenged, she would sometimes announce tersely, 'I'm right, I'm right,' and become impervious to influence of any kind.

Her parents who set great store by decorous manners did not permit her to enter the living room while there were guests present until she had mastered the art of curtsying properly. The patient, much later in therapy, recalled her debut

⁵ It is interesting to note here the use of the dreamlike images used by the therapist in his effort to caricature the exaggerated manner of the patient Kris (1951) has pointed out that the formal language of caricature like that of dreams owes its nature to the operation of the primary process but that whereas in dreams the ego abandons its supremacy and the primary process obtains control, in wit and in caricature this process remains "in the service of the ego."

as a young curtsy er when she bowed so low that she fell flat on her face arousing much consternation in her parents and merriment in the assembled guests. It seemed quite clear in the context of this later discussion that while her conscious wish had been to produce the most perfect curtsy ever seen, she was at the same time teasing (or better here, mocking) her parents by producing a live caricature of the behavior they were demanding and directing attention to herself as an awkward but lovable buffoon. Thus, while we may suppose she provoked a barrage of benevolent teasing from her parents' friends, she was hostilely unmasking her parents as shallow, pretentious people.⁶

The fragility of this developing effort to find in the comic performance a partial solution is indicated by the fact that, at least at the outset, Allerton had not the conscious intention to "make fun of" herself or anybody else. She was, so far as she knew, just trying to be a 'good girl.' This early development stands in contrast to the patient, Catherine, described by Annie Reich (1949), who from childhood on had the conscious ambition of becoming a professional actress of comic roles.

As Allerton grew older, her position in the family as the "teasee" became more firmly entrenched, this spilling over frequently into being an object of ridicule by her mother, who with deep sarcasm would refer to her as "mother's a angel child," would taunt her about how "ugly, fat, and awkward" she was, and who on one occasion had the child's hair cropped, being then both pleased and amused when people mistook Allerton for a boy.

Gradually, Allerton began to cut down on her active ingratiation efforts with her mother, continued sporadically to try to woo her father by learning to play the violin, and turned most of her available energies in two directions: on the one hand to her year-older sister, Helena, whose jester, laundress and desperate emulator she became, and on the other to a warm devoutly Catholic nursemaid employed to look after her.

Helena was clearly the parents' favorite child, she looked and behaved quite like her overelegant mother, took it for granted that she should be attended by her lady in waiting, Allerton, and did not hesitate to accept most of the latter's weekly allowance as part of the natural course of events. It would appear that Allerton transferred to her sister—overtly, at least—all of the previous ingratiating, self-abnegating, engulfingly "giving" attitudes held toward her mother. She

⁶ Kris (1951) has emphasized the intent to unmask or degrade in the graphic caricature which must resemble the subject if it is "making fun of," but which "overcharges" the representation in such a way as to make palatable and masterable the underlying aggression by its "close alliance" with the comic effect of wit. He says that in children "... fun is over and over again favored as the chosen means of mastering aggression, or more correctly, ambivalence ... certainly the comic in its tendentious forms helps in obtaining mastery over affects over libidinal and aggressive tendencies warded off by the superego: the ego acting in the service of the pleasure principle is able to elude them by taking the path of comic expression. The instinctual trends of the Id are given their way but this does not mean that they are gratified in their true and original form. Instead of a direct action, we have a reproduction, the half measures characteristic of the comic" (p. 185).

added to her lavish generosity and servility the role of 'Princess Helena's jester,' gradually becoming a skillful raconteur. At the same time, she became Helena's 'promoter' in school elections, vicariously experiencing the latter's triumphs as her own.

Her relation to her Catholic nursemaid, however ambivalent, was probably the most positive and nurturing of her childhood. She would eat in the kitchen with her, as indeed she preferred to do with all the servants, and would listen rapt to religious discourses. She became converted to Catholicism when she was seven and remained secretly a Catholic until she was twelve. At eight, however, she confided to Helena—it is difficult now to assay with what degree of seriousness—that she had decided what she would like to be when she grew up: a 'strip tease nun'.

This life plan sums up in a most succinct and comic image the variety of drives and counterforces in this little girl. On the one hand she styles herself as a being who denies all need for personal nurturance, dedicated to the humble generous service of others, concealing her body in long black clothes, and devoting her life to the spiritual propositions put forth by her beloved Catholic nursemaid—a life largely devoid of any 'hungry,' hostile, sexual, or exhibitionistic impulses. And at the same moment, she tells us that she wants to display her body not merely shamelessly but in the cynical tantalizing style of the strip teaser who frustrates the onlooker by a skillful juggling of giving and withholding, that in her secret defiance she wants to be the baddest most obscenely provocative creature she can imagine. In this fantasied exhibition, there is very likely also the element of a phallic display as an expression of her strong masculine aspirations (Lewin, 1933).

By rolling all of these into one "career," she makes of herself an impossible comic figure who will not only scandalize her parents but who will disappoint even her consciously cherished nurse. The mocking aggression in this fantasy is only thinly defended against, the hostility is muted by the fragile denials and reaction formations, and by its comic nature. It is striking too that in this fantasy she reverses roles and becomes a frank exhibitionist as well as the active teaser.⁷

It is hard to tell how early Allerton's characteristic projective mechanisms put in their appearance. It is certain, however, that by the time she was ten years old, projective mechanisms were among her preferred modes of defense. She not only projected her intense demands onto her chosen love objects, leading

⁷ This interchangeability of roles has been noted by Jacobson (1916). In her discussion of two patients, a man and a woman—each with a history of having been teased or ridiculed. Both gradually developed the skill of humorous storytelling where often their retaliation would take the form of 'unmasking the others.' Of special interest is the fact that the woman, as she would go into a depression would begin to identify herself both in her dreams and her associations with the same persons who otherwise would become targets of her sardonic humor. Similarly, in the case described by Spurling (1951), there is a continuous exchange of roles. In the young woman who works hard on the one hand with both analyst and lover to provoke a teasing attack of the sort she had experienced with her father—and on the other is the active teaser who "kicks the pants off men while deceptively biding on to her own."

to limitless self sacrifice and "giving", she was also quick to feel "let down," mistreated, picked-on and betrayed. As with most paranoid developments, there was often a core of truth in her accusations substantially abetted by her unconsciously setting up situations in such a way as to alienate her friends. Yet the degree of suspiciousness of the motives of all people seems early to have begun to transcend normal limits. She developed a hard layer of cynicism overlaying her intense yearning to be a cherished well fed little girl and began to weave subtle intrigues among her schoolmates, playing one against the other—always in a kind of conspiracy with the one she was with at the moment—and always fearing they would all get together one day and then band against her.⁸

Even her relation to her adored sister Helena began to break down, climaxed by her saving for two years what remained of her weekly allowance, in order to buy Helena a wristwatch for her birthday. The latter tossed it casually into a drawer—in Allerton's opinion, probably disdaining so "cheap" a gift. Allerton reported much later that she felt utter despair at this, but was able to meet the crisis only by offering Helena new and varied kinds of personal maid service and by continuing as she put it, "to keep her laughing."

During the course of the history taking, she maintained that she possessed only one fantasy and that one over and over, the details always being the same.⁹ She is very ill with some fatal disease that does not appear to be her "fault." As she is about to die the members of her family are gathered about her, her mother and sister suddenly discover that they love her and tell her so. At this moment she dies and only after her death does her father discover that he loves her too. She had played this scene thousands of times and dreamed it repetitively as well. She added later that from the age of nine on, she had the conscious determination that she would make this fantasy a reality before she was eighteen. Here too we see—in addition to her immense yearning to wrest love from her family—a bitter caricature of her demanding hypochondriacal mother who would constantly go to bed with various infections, commanding thus everyone's undivided attention.

Allerton maintained that her need to die preceded her conscious wishes to kill her mother, dating the latter from the age of twelve. She wanted it clear, however, that these impulses "had nothing to do with anger, whatsoever." She never felt angry with her mother, only hurt by her and therefore concluded her

⁸ It is of interest to note that the adult patients previously mentioned, described by Jacobson (1916) and Sperling (1951), seemed also to set up such complex life situations in which there was a constant danger of a triangle being brought to light or of some precarious set of personal "politics" collapsing. Also in these patients as in the case described by Annie Reich (1919) there are indications of the presence of projective mechanisms.

⁹ The crucial role of the tenacious conservatively stereotyped fantasy in the "masochistic character" has been stressed by Reik (1911). He says "The fantasies are comparable to an anticipated memorial to the ego of the day-dreamer . . . the enduring person becomes victorious. Is appreciated and loved is most honored where he had been rejected before . . . The aggressive and ambitious, revengeful and violent in his actual aims, the parrying of which resulted in the genesis of masochism, rise again in the fantasized satisfaction."

mother should be coolly removed from the scene, but without anger. We can suppose that her unconscious sadistic fantasies actually antedated the conscious suicidal program and erupted occasionally later in the form of obsessional ego alien ideas of killing her mother.

Concurrent with these developments, Allerton began to crystallize her conscious formulation of all her human relationships: "All people are untrustworthy and fickle. Without exception they will use you and sooner or later, they will drop you." Much later, at the height of her illness, when she became actively and dangerously suicidal for a time, she elaborated this theme in a desperate way. She must prove that the therapist, too, fitted this formulation and if she could succeed in provoking the therapist into dropping her, her last obstacle to suicide would be gone. The belief that she must inevitably be "used" and then dropped had a distinct paranoid flavor, inasmuch as at this time she would admit to no share in bringing her relationships to a catastrophic end, viewing each denouement as an event which took place routinely in spite of her having remained a devoted, generous friend or loyal jester throughout. Her unrelenting possessiveness and her subtle stimulation of resentment and guilt feelings by her covert demands became clearer to her only late in her therapy.

Before proceeding to the account of the course of Allerton's deepening illness and of her course in treatment, I should like to stop for a moment and take stock of these selected fragments of her history. This stocktaking will serve two purposes: to sum up the material so far, and to suggest several modifications and a systematization of current hypotheses regarding the nature of "moral masochism," the psychology of the "teasee" being a special case of this broader problem. These theoretical issues will be sketched here and further elaborated in the concluding section of this paper. The subsequent development of Allerton's illness and her recovery seem to provide further evidence for the propositions I am about to offer.

On the level of clinical observation, Reik (1941), side-stepping Freud's theory of the death instinct, an issue to which I will return later, has suggested that it is insufficient to regard the phenomena of "moral masochism" in superego terms, as simply an unconscious need for punishment or even as sadism turned against the ego. While he believes that the appeasement of guilt feelings is of importance, he implies that masochism is nonetheless essentially a complex expression of ambitious, aggressive, revengeful, defiant impulses revealed in fantasy or circuitously in action against an actual person or persons, though often with what he calls "a reversed sign." He emphasizes the crucial importance of the sadistic fantasy, regarding it as the soil in which masochism grows, and far from feeling as Wilhelm Reich (1933) did—that in masochism we see an "inhibited exhibitionism"—he maintains that the "demonstrative" quality in parading one's harmlessness, generosity, ineptness, or suffering

is actual exhibitionism, again with a reversed sign and with the aim of hiding something else—hostile, stubborn—even vainglorious—tyranny. The data from our young patient bring into high relief the proposition that whenever a masochistic development achieves any significant proportion this camouflage is often unsuccessful, and that the concealed impulses are experienced by those on the receiving end as aggression proper or desperate demand. We shall see that this is clearly the case when in an acute decompensation the various ego functions which have buffered the infantile drives suffer a partial or total collapse.

Even without the further clarifying material of our case brought out during such a severe period of decompensation, the highly condensed history so far brings confirmatory data for Reik's hypothesis. Allerton it will be recalled, was emotionally deprived, and intensely demanding of attention from an early age, with periods of impervious stubbornness with regard to food or to the unalterable correctness of her opinions. Her characterological techniques for dealing with her deprivation and her rage took on one level the form of extreme self sacrifice and abdication of personal achievement, in the excesses of these, we see already an accusation of her parents. On another level, we see early her talent for presenting herself as the lovable clown, who extracted affectionate responses from people while hostily unmasking her parents. On yet another level, her characteristic projection of her own needy and exploitive impulses is seen in her view of all her relationships as a situation in which she must 'give' limitlessly and/or be "dropped" when her usefulness comes to an end. The eruption of the openly sadistic fantasy (of killing her mother) and of the 'victory in defeat' fantasy of her own death—which brings everyone's love—testify to the weakness of all of these defensive and adaptive efforts. While Reik's focus on the importance of the sadistic character is borne out in this case, it seems to me that his presentation largely omits the crucial importance of the *projective mechanisms* and, in common with most other recent discussions of such complex formations as masochism, does not allow for a clear conceptualization of the relevant phenomena in terms of a steadily shifting balance between drives and ego functions.

To put it more systematically: those clinically observable phenomena which we usually subsume under the heading "masochistic" do not appear to be simply direct instinctual expressions (Freud, 1920) nor, as some have described them, only defense mechanisms (Bergler, 1949; Berlin, 1967). They are rather highly complex sets of configurations which include special varieties of infantile need and rage being put against a variety of and among defense mechanisms and in interplay with the available

creative or adaptive ego functions, whether these be humor, aesthetic talent or whatever. Significant redistributions of psychic energy as in a decompensation and a rebuilding bring various aspects of this complex interplay into relief.

Although it does not yet seem possible to elaborate in systematic detail the precise nature of the underlying drives and defenses which are *specific* for the formation of those psychological phenomena commonly recognized as masochistic, it does seem possible to suggest a schematic outline of them.

First, on the side of the primitive drives. Reich (1933) suggests that an excessive, essentially unmettable demand for love (plus an unusual disposition to anxiety) is the starting point for the consequent rage which develops when this demand is not met. The complex and infinitely toned varieties of masochistic formations express thus simultaneously the unusually strong need and the consequent aggression when this need is frustrated in fact or fantasy.

Second, on the side of the defensive functions of the ego. Although the literature on masochism rarely discusses the problem in these terms, the clinical material offers a fair consensus that the triad of denial, reaction formation, and introjection is regularly present in the masochistic character. The form of defense rarely emphasized is that of the *projective mechanisms*. The available clinical data suggest that these have a singular importance for the masochistic formation.

We see first the projection of insatiable demands in the masochist's assumption that all people are as imperiously needy as he and he must therefore be inexhaustibly 'giving'. In short, when he is functioning well he gives his objects what he would like to get from them. As the hostile component in his ambivalence mounts, this 'giving' becomes an aggressive smothering attempt to control—experienced by the object not as a gift but as an enslavement. We see also, however, his *projection* of hostile impulses and accordingly, the provocative gingerly testing approach to all human relations with the pervasive feeling that his chronic misfortunes and disappointments are the other person's fault. He is ready to feel exploited as a direct consequence of his projected exploitiveness. In a more complex fashion the projective mechanism in a masochistic formation may be used as the vehicle for what one might call a benevolent paranoid attitude, where the usual *denials* of, and *reaction formations* against, hostile impulses are projected wholesale and people are seen as essentially good and without malice, the Pollyannaism so familiar in the masochist.

One could multiply examples of the variegated forms which these four defensive processes may take including those special combinations which

and of dread of ridicule from his superego centered his attention on his feelings of shame in order to activate his defense against his instinctual desires. The focusing of his attention on his feelings of shame deflected it from his learning tasks.

Case 12 A boy of ten had been stealing. He felt very guilty about his actions but the feeling of guilt did not stop his stealing which was continued because it was a distorted expression of certain unconscious instinctual desires and therefore drew strength from his instincts. He also became afraid he would be detected and punished. The fear of detection was an attempt on the part of the superego through projection to reinforce its prohibition against the strength of the instinctual drive in a manner similar to the mechanisms in Case 11. This increase in the strength of the superego prohibitions focused the ego's attention on the feeling of guilt and deflected it from the task of learning his school work, which suffered badly during this period of worry.

During the latency period and early adolescence the attention is focused on feelings which indicate the presence of superego prohibitions usually when the prohibitions are directed against sexual drives as in Case 11. The focusing of attention on superego manifestations is usually quite marked and the consequent deflection of attention from the task of learning is indicated by a quite serious, although perhaps short lived, decrease in academic achievement. It is unfortunate that these deflections of attention from whatever cause, result in the child's not learning the particular sections of the subjects being taught at the time the attention is deflected. The results of this lack of learning however short lived it may be, show consistently in difficulties in mastering later aspects of the same subjects and the individual may labor under inadequate skills in these subjects for the rest of his life unless he receives special tutoring in the parts he did not learn. It is the duty of the educator to see that this special tutoring is provided in all these cases after the conflict has been solved. This is seldom done at the present time unless the learning loss has been tremendous but here the intrapsychic conflict is usually deeper seated and more serious than in the cases I have been discussing.

C Engrossing Conscious Feelings of Horror and Fear

Case 13 A girl of twelve began to fail in her school work. Shortly before the failure began she had been told by her friend about the phenomena of child birth the friend depicting vividly and with much exaggeration the painfulness and bloodiness of labor. The patient formerly had been quite satisfied with her feminine role and was looking forward with eager anticipation to the time when she could be married and have many children. Now these desires and anticipations became terrifying. In order to integrate these two incompatible ideas she had to focus her whole attention on this conscious conflict so that she was unable to attend to her academic work.

Case 14 A boy of fifteen began to fail rather suddenly in his school work. He lived in an unsupervised home and had been having regular intercourse with his sister, a year younger. About this incestuous relation he apparently had no feelings of guilt. However, as his sister approached her fourteenth year, he became frightened lest she become pregnant. He had no knowledge of contraception and was in conflict between his desire to continue his sexual gratification and his fear of impregnating her with the consequent detection and scandal. His attention was focused on this conflict and so was withdrawn from his task of learning. Here the conflict was between two different ideas in his ego and as in the last case the attention was focused on it in order to reinforce the ego's synthetic function.

D Engrossing Conscious Involvement with Instinctual Desires

Case 15 A girl of fourteen rather suddenly began to fail in her school work. At this time she had become aware of a strong desire to masturbate to which she succumbed at intervals. After each time, however, she experienced great remorse and fear; so great that she preferred to walk the floor all night lest by getting into bed and trying to go to sleep she might succumb again. Of course the fatigue on the next day interfered with her ability to learn. Her attention was focused night and day on the problem of whether she would masturbate or not and so deflected from her task of learning. In this case the conflict was due to the strength of her instinctual desires and their demands for gratification. These desires were opposed by her ego fears with regard to the results of the act and by her feeling derived from superego prohibitions against the unconscious fantasies during masturbation that masturbation morally was wrong.

The manner in which the strength of an instinctual impulse focuses attention on its need for gratification and therefore interferes with other ego functions such as judgment besides deflecting attention from other tasks at hand, is well illustrated by the following case.

hatred in a constructive way but the strength of the anger and hatred overcame his judgment and focused his attention on it rather than on the activity in which he was engaged and in which he apparently was interested.

E Focusing of Attention on Daydreams

In the cases I have discussed so far it will have been observed that the attention of the patient has been focused on unpleasant conscious feelings and therefore deflected from the task of learning academic skills. In the next group of cases the learning failure results from the deflection of the attention from the feeling of worry, which then is not recognized, to fantasies which may be conscious or unconscious and whose purpose is to comfort the child about some feeling of unpleasantness. Freud (1911) has discussed the dynamics of daydreaming. He says, 'There is a general tendency of our mental apparatus which we can trace back to the economic principle of saving in expenditure, it seems to find expression in the tendency with which we hold on to the sources of pleasure at our disposal and in the difficulty with which we renounce them. With the introduction of the reality principle one mode of thought activity was split off, it was kept free from reality testing and remained subordinated to the pleasure principle alone. This is the act of fantasy making which begins already in the games of children, and later, continued as day dreaming, abandons its dependence on real objects.'

During the first few days or few weeks at boarding school the learning ability of a child often decreases. If he is questioned it will be found that he is centering his attention on daydreams about his home and his family and has deflected it from the task of learning. He may not feel unhappy or anxious, as other children may do in the same situation and which are usually the feelings that accompany homesickness in the first day or so at camp, because he is focusing his attention on pleasant memories but his ability to learn suffers during this time. In this instance the child is conscious that he is daydreaming. However, during World War II a condition known as cryptic nostalgia was reported (Wittson, Harris, and Hunt, 1943). Certain soldiers, shortly after their induction, apparently were unable to obey orders, to follow even the most simple instructions, to remember anything for even a short period of time, they behaved as if they were quite feeble minded. Their induction records, intelligence, and aptitude tests etc., usually showed their intelligence to be above the average. The patients themselves did not understand what was the matter with them and were unaware of any feeling of dislike for the service, their colleagues or superiors or of any feeling of homesickness. Careful investigation however, revealed that they were thinking constantly about home but were not aware that they were doing so, till

V. DIMINISHED CAPACITY TO LEARN BECAUSE THE LEARNING PROCESS ITSELF IS INVOLVED IN A NEUROTIC CONFLICT

It may be considered that I have discussed already all of the types and causes of learning disorders particularly when I have included the deflection of attention from the task of learning because of conscious and unconscious intrapsychic conflicts. However, it may be asked, "Does the concept of deflection of attention account for all types of learning difficulties based on intrapsychic conflicts?" Certainly it plays a part as a mechanism that interferes with learning but in itself it does not seem to account for certain cases of learning difficulties, encountered particularly in adolescents, nor does it take into account the possibility of the actual involvement of the learning process itself in specific types of conflicts between the ego and the superego and id. Learning of any kind, but particularly the learning of scholastic skills, is a function of the ego. The energy utilized by the ego and by the superego basically emanates from the instincts. It would seem probable that certain learning difficulties arise because the learning process itself becomes part of whatever intrapsychic conflicts are proceeding between the three parts of the personality and not simply that the attention is deflected from the subject to be learned to the intrapsychic conflict.

Freud (1905) pointed out long ago that the functions of the ego in the psychic sphere have their prototype in the functions of the ego in the physical sphere. The digestive activity of the body ego is the prototype of learning as a psychic ego function. The digestive activity consists of four parts:

- (1) The taking of food into the body through a special organ, the mouth and the upper part of the gastrointestinal tract.
- (2) The digestion and assimilation of the food by a complex of special organs and their activities.
- (3) The putting out of the results of the digestive process, part being put out immediately as energy, part being stored for future production of energy, and part being excreted as unusable.
- (4) The energy formed through digestion is used by the ego in the functioning of the total individual

Similarly the learning function consists of four parts:

- (1) The intaking of information through the special senses and other parts of the sensory nervous system.
- (2) The correlation and association of these sensory impressions among themselves and with the memories of previous sensory impressions through the association pathways of the cortex and subcortex.

(3) The putting out of the end products of these association processes through motor activities such as writing, speech, etc

(4) The use of these end products by the ego in the successful functioning of the total individual

Therefore, just as nutritive disorders may arise because of disturbances in the organs and their functions at any one of the four steps, and just as disorders of the organs and the function of the gastrointestinal tract may result from organic changes or from the influence of emotional conflicts, so the learning process similarly may be disturbed. In gastrointestinal disorders, a disturbance in the function at one step is bound to result in greater or less disturbance in all the other steps. The same result also happens in disorders of learning.

A Disorders of the Use of Learning

The acquirement of knowledge and of skills is used in life to accomplish three desires

(1) Successful competition with contemporary rivals

(2) Successful advancement in the chosen sphere of life

(3) The attainment of ultimate success, i. e., of power, money, position, and prestige

Each of these human desires exist throughout the whole of life but are given somewhat different conscious connotations at different periods of life. In the period of early childhood the desires are expressed in purely physical concepts. The little child wishes to be grown up and do all the things that adults do. In order to do this he has to be more capable physically and he tries to accomplish this result as quickly as possible. If he could be more competent physically he could compete more successfully with his rivals. In short, during the period of early childhood success is a matter of increase in size and power of his body. In his mind, his body is equated with his penis so that during this period his wishes and endeavors are to make his penis bigger and more competent to use in accomplishing his desires in life and in competing with his rivals. With the onset of the latency period such concepts are repressed to some extent and the wishes are attached to much broader fields of endeavor than the purely physical and sexual. The equation of his body with his penis becomes more or less unconscious but his ambition to be physically more capable still remains.

During the latter part of the latency period and in adolescence, although the desire to be physically more capable persists, it becomes more and more replaced by the desire to be successful in vocational and erotic ventures and the individual desires to learn all the skills he can to be able to attain prestige and wealth and to attract the desired mem

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(2) Successful advancement in the chosen sphere of life

(3) The attainment of ultimate success i. e., of power, money, position, and prestige

Each of these human desires exist throughout the whole of life but are given somewhat different conscious connotations at different periods of life. In the period of early childhood the desires are expressed in purely physical concepts. The little child wishes to be grown up and do all the things that adults do. In order to do this he has to be more capable physically and he tries to accomplish this result as quickly as possible. If he could be more competent physically he could compete more successfully with his rivals. In short, during the period of early childhood success is a matter of increase in size and power of his body. In his mind, his body is equated with his penis so that during this period his wishes and endeavors are to make his penis bigger and more competent to use in accomplishing his desires in life and in competing with his rivals. With the onset of the latency period such concepts are repressed to some extent and the wishes are attached to much broader fields of endeavor than the purely physical and sexual. The equation of his body with his penis becomes more or less unconscious but his ambition to be physically more capable still remains.

During the latter part of the latency period and in adolescence, although the desire to be physically more capable persists, it becomes more and more replaced by the desire to be successful in vocational and erotic ventures and the individual desires to learn all the skills he can to be able to attain prestige and wealth and to attract the desired mem

bers of the opposite sex (I am speaking here of the male, the criteria of success for the female are somewhat different)

The uses of the acquirement of knowledge and of skills may become disordered. In my experience disorders of the use of learning are seen more commonly in adolescence than during the latency period. They are more readily observed then, because more emphasis is placed on the adolescent taking responsibility for his school work than is placed on the child of the latency period and therefore his shortcomings are more glaringly evident. It may result also from the fact that the reactivation of sexual activity in adolescence reactivates the unsolved oedipal conflicts and the defense mechanisms which were used to make temporary peace with these conflicts are reactivated at the same time and become more apparent, whereas during the latency period both the unsolved oedipal conflicts and the defense measures exist at a lower ebb of activity.

The most common disorder of the use of learning is an inhibition of the function. Freud (1926) states that 'inhibition in the field of occupation [and learning is the occupation of the child], which so often becomes a matter of treatment as an isolated symptom, is evidenced in diminished pleasure in work or in its poor execution, or in such reactive manifestations as fatigue (vertigo, vomiting) if the subject forces himself to go on working'. He defines an inhibition as the expression of a functional limitation of the ego. The ego renounces the functions proper to it for one of these reasons:

(1) In order not to have to undertake a fresh effort of repression in order to avoid a conflict with the id

(2) In order not to become involved in conflict with the superego. Here the inhibition evidently subserves a desire for self punishment as for example those in the sphere of vocational activity frequently do.

(3) Because it is so impoverished with respect to the energy available to it that it is driven to restrict its expenditure in many places at the same time.

Inhibition of the use of learning comes in the second group. In these cases the ability to take in knowledge, to digest the knowledge and to give it out all function perfectly. The difficulty lies in the inhibition of the use of the learning. In this it resembles very closely sexual impotence and therefore I would like to designate this group of cases as suffering from Learning Impotence. Disorders in the use of learned knowledge usually are an expression of sibling rivalry or the result of feelings of guilt or dread of castration.

Case 19 A girl of twelve disliked reading and practically never opened a book unless she had to. She was very interested in art for which she had considerable innate ability. Her sister, fifteen months older, was very interested in reading. When the patient was small the older sister had been much admired for her beauty whereas the patient had been rather ignored by the majority of the relatives. The older sister had been physically cruel to the patient until the latter discovered that biting was an effective method of retaliation. This resulted in punishment. Deterred by this from destroying her envied and hated older sister, the younger proceeded to select areas of endeavor in which there was no chance of her sister stealing from her the admiration and love she craved. In a lesser degree, because the necessity was less than in Case 18, the disorder in the use of learning academic subjects was an attempt to solve the sibling rivalry situation.

It seems to me that this method of solving the sibling rivalry situation, i.e., the development of interests divergent from that of the rival, is a very frequent and very satisfactory method in comparison with the bitter hostility and furious competition that is seen when two siblings endeavor to maintain the same interests, friends, etc. However, in serious sibling rivalries the satisfactoriness of this technique may result in serious disabilities in the use of learned knowledge. In these cases the ability of the ego to use learned knowledge is either restricted or accentuated unconsciously in order to avoid pain and suffering at the hands of the older sibling or the humiliation of failing to attract the desired degree of parental love.

2. DISORDERS IN THE USE OF LEARNED KNOWLEDGE BECAUSE OF FEELINGS OF GUILT OR DREAD OF CASTRATION

a) Examination Anxiety

Perhaps the simplest example of the effect of feelings of guilt and of dread of castration on the use of learning is found in the universal examination anxiety, severe examples of which are seen fairly frequently. Psychoanalysts have seen many examples of the dynamics of examination anxiety in recent years during the processing interviews of applicants for admission to the psychoanalytic training institutes. Even among these experienced psychiatrists examination anxiety is as universal and severe as it is among grammar school, high school and college students. Long ago Freud (1900) drew attention to the fact that when a dreamer dreams he has failed in an examination, it is usually in a subject in which he really did well while at school and never in a subject in which he really had failed. Such a dream tends to occur on the eve of a day on which the dreamer is faced with a responsible task which might end in his dis-

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grace The dream comforts the dreamer about this possibility in saying, "See you don't need to dread the task tomorrow, don't you remember that you felt you might be disgraced on this particular examination but instead you came through with flying colors?"

From this example we can see that one cause of examination anxiety is the fear of disgrace The child dreads that his teachers and parents will find out that he has not applied himself diligently, will discover his shortcomings and will humiliate him If this fear associatively is connected in the unconscious with the memory of the humiliation the child suffered earlier when he discovered how much smaller his genitals were than those of his father, the examination anxiety will be enormously increased, even though he had applied himself diligently to his pre examination studies Also, if associatively it is connected in the unconscious with strong feminine desires, which are kept unconscious because they conflict with masculine pride, the examination anxiety will be increased because it will represent consciously an unconscious wish to fail

Instead of the fear of disgrace, examination anxiety may be rooted in the fear of being found out and punished for lack of diligence If this fear is associatively connected in the unconscious with strong fears of punishment by castration for masturbation the examination anxiety will be increased There is another cause for greatly increased examination anxiety To be successful in the examination is to progress onward in ambition If this idea is connected associatively in the unconscious with the oedipus fantasies of killing the father and taking his place, and these fantasies are not yet resolved, but still dreaded lest the father retaliate in like kind, then there will develop a fear of succeeding and perhaps also a desire to fail Both of these appear in consciousness as greatly increased examination anxiety

Every child suffers from examination anxiety In children whose infantile intrapsychic conflicts are not well resolved, it will be very severe, perhaps so severe that the child becomes paralyzed in the examination and either does very poorly, cannot complete the task, or refuses to take the examination The examination anxiety in these cases serves as a method of inhibiting and restricting the ego in order to avoid a fresh attempt at repression

b) Difficulties in the Use of Learning Due to Repudiation of Learning because It is Associated with Masculinity or Femininity

Learning of academic subjects and the use of such learning may have acquired for the child a specific masculine or feminine flavor as the result of the parental attitudes toward learning In a specific family if the

mother is very interested in learning while the father is indifferent, the boy readily may come to regard the desire to learn academic subjects as a feminine attribute. In this way the desire to learn becomes connected with the passive receptive feminine desires which he dreads lest their gratification result in castration. As a result such a desire has to be repudiated.

Case 20 A boy of twelve whose intelligence was above the average did not do nearly as well in his school work as was to be anticipated. He seemed to be ambitious and because of his high intelligence attained a certain degree of success. He might set an educational goal for himself but as soon as he attained it, which he seemed to do with little effort and without any inner recognition of pleasure in attaining it, he seemed completely satisfied and was surprised and disconcerted to find that this goal entailed new demands on his efforts and a further need to exert himself. Each attainment was followed by a slump and an apparent lack of interest in any further goals or even consolidating his present position. He could apply himself with great interest and success to a subject for which he received no marks. He had little interest in those subjects that would bring marks but because of his intelligence learned enough automatically to get by. His main continuing interest seemed to be in baseball which he played in and out of season. There was a lack of flavor to this interest for he did not seem to care much whether he helped his side through his skill. He felt some pride if he would make more hits than his friends but his main ambition was to have the best and most expensive glove, bat and ball. His father was a rather apathetic man who held a routine position and had a desultory interest in baseball which he played occasionally. His mother was a very ambitious and very driving woman who supplemented the family income and had great professional and cultural ambitions for her children, particularly for her son. Although she read little herself and certainly much less than her husband, she implied that learning was tremendously important. She delayed the patient's entry to school one year in order that he and his younger sister might start school together. The patient's unconscious concept of learning was the fantasy that his teacher wanted to force the knowledge down his throat. This would make him eventually become like him and so he would not be himself. (I will refer to this fantasy again later in another connection.)

In his mind learning and ambition were traits linked with those of the female while apathy, desultoriness, indifference to ambitions, lack of interest after a goal had been attained, indifference to learning and an interest in baseball (which his mother constantly deprecated) were linked with masculine traits. Despite an avid and all-consuming curiosity, his masculine pride revolted at any desire to learn and by avoiding any use of learning he was able to comfort himself that he was not feminine and was not castrated.

Case 21 A boy of ten, also of high intelligence, did fairly well in his school work but consciously disliked school. He preferred to be considered a toughie and was a behavior problem in the classroom to such an extent that his good

academic grades were reduced by his poor grades in conduct. When his teacher tried to help him he would spend his time arguing with her to the point where he skillfully evaded learning the subject. He felt bitterly humiliated because he did not immediately possess all knowledge and was furious if he found he had to learn something he did not know.

His father had had little schooling although he was innately alert and a fairly successful business man. His mother who quarreled constantly with her husband was an immigrant from another country. She had no formal education in English (she could neither read nor write) but came from a family with a high rabbinical tradition. She had great ambitions that her children particularly her son should attain professional standing. A sister a few years older than the patient was extremely interested in learning and quite successful in her school achievement.

The patient believed that a desire to learn was *sissey* a female prerogative etc. In his unconscious the patient equated receiving instruction with anal rape. His masculine pride revolted against these ideas and his behavior in school was an attempt to prevent any encouragement of his desires to learn.

Case 22 A girl of eleven did very poor work in arithmetic. She objected to learning the use of a protractor but she was extremely envious of the slide rule used by her much older brother. This brother who was very good in mathematics was her hero whom she respected and envied. He and his slide rule represented perfection in mathematics. She was certain that boys had a peculiar innate ability in mathematics which girls did not possess. When arithmetic demanded from her some energy in learning she felt inadequate because she did not possess the particular ability (slide rule penis) which her brother had and which she envied. Therefore as she did not have the equipment necessary to learn arithmetic she had to fail.

The effects of the association in a child's mind between his sex and the sex of the parent who is most interested in learning form the basis of many more learning disabilities than educators at present are aware of. The unconscious fantasies in these three cases I cited indicate that these children were quite neurotic and their cure could be obtained only through psychoanalytic therapy. However many cases of disorder of the use of learning based on the concept that the desire to learn is a trait or ability of the opposite sex do not suffer from a serious neurosis. All that really is required for their treatment is the introduction of a teacher of the same sex as the child who himself is interested in learning. Through the process of identification with such a teacher the child is able to break up the erroneous association that in his mind consciously or unconsciously makes learning a sex linked trait. It is important however, that such cases be studied by a psychoanalyst in order to exclude the presence of a serious neurotic disorder.

c) The Inhibition of the Use of Learning to Avoid Feelings of Guilt and Fear of Castration

(Educational Impotence)

Case 23 A fourteen year-old boy was referred for treatment because he was failing in his school work, although his intelligence was above average. He was just passing in mathematics and science and was failing in social studies, English and art. In the classroom he either did no work at all, or defiantly disturbed the routine by reading books during the class period and mimicking and ridiculing the teacher.

He had done extremely well in the first two grades. He did less well in the third grade, possibly because he had changed schools. In the fourth grade he improved. In the fifth grade, when he was ten, his teacher began to complain of his behavior. He was fascinated by matches and fires and once started a fire under his desk. However, this preoccupation did not last and he had little trouble during the next two years. His real school difficulty began at the age of thirteen. He failed at the second report period and was so apprehensive about his failure that he altered his report and truanted for two days. He was able to make up his work and was promoted. During the next year his achievement and behavior were as I have described it.

At home he seemed to be obstinately lazy. He disliked getting up in the morning, having to be called a great many times. He dawdled in the bathroom, sometimes for as long as an hour, in dressing, in eating his breakfast, in doing chores or errands, in doing his homework, in coming to meals and in going to bed. His mother tried to hurry him by constant reminders which soon turned into angry nagging, so that usually breakfast ended in a flood of angry weeping on the mother's part and sullen unhappiness on his.

Part of the mother's angry nagging seemed to be somewhat justified by the boy's tendency to dawdle but the greater part of it did not seem to be so, because there was more nagging about nonessentials than about essentials. She was a disinterested, unhappy woman and everything that happened in the home got on her nerves. She also suffered from migraine. She was overprotective and overrestrictive to both of her sons but much more so to the patient.

The father, whose hours of work were long and often necessitated his rising at 3 A.M., tried to keep peace between his wife and his son by being consistently on his wife's side and severely condemned the boy even when he was obviously not in the wrong. He maintained this attitude not because he believed that parental differences of opinion were harmful to the children but because he wanted some peace and quietness in his home.

The patient was the older child, having a brother four years his junior. Both parents seemed to love and respect the younger boy more than the elder. The patient dates his difficulties from the birth of his younger brother and although he quarreled with his brother and often picked on him, he was unconsciously of his feelings of jealous hatred to him. His feelings of jealousy, more

marked than the situation justified were conscious in his relation to his school mates. At the time of his brother's birth and for a number of years afterward the family who was Jewish lived in a Gentile neighborhood and the patient was ostracized by the Gentile boys so that he was reduced to playing either with girls or with his brother. In order not to lose his brother as a playmate he repressed his hatred of him and displaced it onto his schoolmates. He tried to overcompensate for his hatred also by seducing his brother into sexual play with him.

The mother's pregnancy with the patient was the cause of the parents' marriage which seemed to be quite an unhappy and loveless one. At the age of one year the patient suffered a compound fracture of the elbow which caused him great pain and demanded a great deal of his mother's attention. He was very frightened of the doctor who had to reduce the fracture and dress the wound. For some time after the fracture healed he screamed with fear whenever he saw a strange man. Shortly after the fracture healed the mother who had breast fed him up to this time decided to wean him and in order to do so sent him to her mother in laws. He was completely toilet trained by the age of eighteen months. His mother restricted his physical activities in fact he was not permitted to play much on the streets till he was about ten. When he was eleven his mother dissatisfied with her role as a housewife started to work and the children were left unsupervised.

The patient's presenting problem was his difficulty in getting along with his mother and his complaint that his father did not support him against her.

He had two main unconscious conflicts. He had a phobia of bodily injury and of developing heart trouble. He became conscious of this when he was about eleven. At this time a girl in his class at school died of a heart lesion. He believed consciously that part of his school difficulty was caused by the fact that his hands got tired so easily so that he either could no longer write or if he did his writing was illegible. He told me that he would rather be considered lazy than angry. He denied consciously any interest in girls. He stated that since he was thirteen years old he felt differently toward girls than other boys did. He disliked them and particularly disliked a girl who was rather maternal. He denied any conscious feeling of love for his mother.

His fear of bodily injury more intense and therefore more crippling to him because of the unconscious memory of his pain and terror at the compound fracture caused him to repress his heterosexual desires and his tender feelings for his mother. It caused him to repress his jealous hatred of his father and of his brother and to overcompensate for this by extreme dependence on his father. This made him feel very inferior to his father. It caused him to repress all hostile feelings, anger, hatred, desire to compete, etc. and so interfered with his competitive drives to achieve success in his school work. He wanted to run away and he had several dreams where he went to far distant places. However these dreams often ended in a conflict with rivals in the new situation. It was this fact that unconsciously prevented him from carrying out his conscious inclinations to run away because he would be no better off in the new situation and made him unable to work in school to the best of his ability.

In order to supplement his efforts of repression he inhibited his desire to use the knowledge he learned to make himself successful lest he suffer the punishment of bodily injury at the hands of his rivals.

His lack of scholastic achievement was also motivated by his unconscious desire to spite his mother who was interested in having him do well in school. His truancy from school also got her into trouble with the school authorities and was done partly for that reason. His conscious fantasies of suicide always ended in his mother's being very sorry for the way she had treated him and in deep grief for his loss. This spitefulness was aimed at punishing her for not loving him as he desired. It contributed also to his desire to avoid his castration fear by changing his active love toward her into a passive wish for her love. Both his poor scholastic achievement and the way in which he spent his money were unconscious attempts to attract his mother's sadistic interest and love.

A great deal of the trouble with his mother centered around his attempts to deny his strong unconscious wishes to be fed by her. Although he ate well he had for many years a marked distaste of milk. His conscious masturbation fantasies were largely about breasts and girls with large breasts. Part of the motivation in not using his learning was an unconscious wish to be the baby he was before his mother weaned him and part was his attempt by refusing to take in knowledge to punish him for the weaning. (The problem of the denial of his oral wishes may also have contributed to his poor scholastic achievement although I could never prove it. I will refer later to this case when I discuss the relation of disorder of oral intaking to failures in learning. I would like to note at this point that although I have tried to classify cases of scholastic failures into various groups all cases show evidence of the dynamics of all the different types. The particular case is placed in this particular category simply because the main dynamics are of that category.)

His denial of his love for his mother because of his castration fear caused his object love for her to regress to identification with her. Several of his dreams showed a wish to be a man who fed people and gave them liquids to drink. Here he identified himself with the nursing mother. Although he smoked and stole money from his mother (who objected to his smoking) to buy cigarettes he objected vigorously to my smoking. This was an obvious identification with the aggressor i.e. the weaning depriving mother.

Besides the oral fixation to his mother this patient had regressed somewhat from the phallic to the anal sadomasochistic level in order to avoid his fear of castration. This was indicated by his great interest in fires and explosives and by his character trait of procrastinating and then suddenly having a desire to work. The accentuation of his sadism was shown in his spitefulness toward his mother and his masochistic attitude to her which caused him to force her to nag him and fight with him. This regression was not a very deep one and had not reached the stage where he really had identified himself with her in order to receive passive anal masochistic gratification from his father. He was not completely oriented to want his father to love him in the way his father loved his mother.

His main problem was an active phallic desire for his mother and his fear of

castration if he did so. His school failure was an attempt to inhibit his use of knowledge lest he be castrated by his father and had the lesser degree of motivation in taking revenge on his mother for not loving him.

This case illustrates the usual dynamics in boys who suffer from a diminished capacity to learn because the use of learning is inhibited by feelings of guilt and fear of castration. In these cases the use of knowledge is equated unconsciously with the use of the penis. The disorder of the use of learning usually begins in early adolescence. Previous to this the patient has suffered from severe phobias but he has never told any one about them. At this time his school achievement is good. By some means he has been able successfully to repress the phobias as in another case I have described (Pearson, 1949 Chapter 13). Shortly after the repression of the phobias, the school failure begins. Usually as in this case, little or no real regression has taken place.

In the next case the dynamics are the same but a major regression has taken place and the use of knowledge has become equated with an anal penis or with early concepts about feces.

Case 24 A boy was referred at the age of fourteen because he was failing in his school work. He was attaining grades very much lower than his ability justified. He was inattentive in class and took no responsibility for completing his required work. Often his mother had to compel him to do his work at which times his marks improved. He had been ill as a child and had had to live in several different climates therefore he changed schools a number of times. He started his school career in a good traditional private school where he did well and received some merited prizes. When he was ten he attended an outdoor school in Florida where his achievement was better than fair. At eleven he entered a boarding school where he received marks which were just passing. The next year he went to Arizona. There he did little work in school until his mother forced him at which time his marks improved. At thirteen he entered another good private school which he was attending at the time of his referral about which time he was expelled. Shortly after this the mother moved to another town and the patient entered public school where his achievements varied. Sometimes he did well at other times he did very poorly. After a year of this his mother moved again and he entered a boarding school from which eventually he was expelled because of his grades and his constant breaking of rules. These were usually minor infractions but were very frequent. Here he had been inattentive had very inadequate routines of studying and doing his school work. Often he would listen to the radio instead of doing his assigned work. He did not seem to flaunt rules deliberately but was late constantly and failed to complete requirements. As an example of his behavior he failed in algebra but received a national award for an essay. At another time he failed in English but obtained high marks in algebra. His IQ was 120.

Socially he had some degree of popularity with boys but usually selected

friends who were not in his social group or were somewhat antisocial. He seemed to dislike girls.

At home his behavior resembled that in school. Although he had had so many illnesses in his life, he took no care of his health. He deliberately exposed himself to poison ivy. He ate irregularly and unwisely. He would fall or jump into the lake when he had a cold. He seldom brushed his teeth. He consistently went to bed very late. He refused to sleep in pajamas—instead slept in his underpants which he wore during the day and which he seldom changed. He seldom lifted the toilet seat when he urinated and seldom flushed the toilet after defecation. He never used toilet paper and therefore his shorts were always stained with feces. He went on hikes through rain and wind in his best clothes. He never untied his shoes so that the backs soon were broken by putting them on while tied. He used his mother's best linen for various chemical and biological experiments. He would throw bloody rags, old swabs, fishbooks, dirty socks, etc., into drawers of clean clothes. He would put cigarette ashes into lamp bases or magazine racks instead of into ash trays. He never shined his shoes, and he put off getting his hair cut as long as possible. As a result his slightly peculiar appearance was made very peculiar by his unkempt hair, face and nails. There were constant difficulties over his use of money, and the size of his phone bills. He would start a household chore but never finish it.

He was the older in the family, having a sister who was born when he was two. She was two inches taller than he was. The parents were divorced when the patient was five. His father was a man whose behavior was unpredictable. He was cruel to his wife and did everything possible to annoy her. As an example, he encouraged the patient at the age of three or four to play with loaded guns. He stuttered and when the patient was three he started to imitate his father's stuttering. The patient was very afraid of his father because he was so rough, but in boarding school he became very resentful to any house father who seemed to favor another boy. His mother was very apprehensive lest the patient become like his father. The patient had not seen his father for years.

The mother was a timid woman who suffered from a phobia. She had been indecisive in her management of both children but particularly of the patient. She had attempted to be "modern" and had allowed them to criticize her openly and constantly. (The children early were encouraged by the paternal relatives to do this.) She had allowed the patient often to do as he liked, whether it was advisable or not, and then, when she became exasperated by the discrepancy between his behavior and her standards, had nagged and pleaded with him. He wanted a rifle when he was twelve, although there were no real opportunities for shooting except in situations where it would be dangerous. She refused, he persisted, she refused. He bought a rifle which she allowed him to keep and use. He wished to drive the car although he was under the legal age. She refused. He persisted so she had him taught and then permitted him to drive her around. (In many cases of this type of scholastic failure the mothers are found to object to some wish of their sons which really would break the law, then to give in and actually to participate in the illegal procedure.)

She seemed to be afraid of the patient, would argue with him and then give

in, would make promises she could not fulfill and even make promises she could fulfill and then not carry them out

The mother herself wished to be a physician and was hopeful that the patient would become one. The patient on his own initiative got a job assisting a veterinarian. He was so responsible for quite a while that the management of the treatment of the animals was left in his hands. After a time he became somewhat careless, quarreled with the veterinarian and refused to work for him any more. The mother preferred the patient's sister, who, however, also showed some antisocial traits.

The patient's acute difficulties started at the same time as the mother's acute neurosis. He wanted his mother to do his work for him, even to the extent of keeping him clean. He stated that he was ashamed of his mother's unconventional behavior and in conversation gave the impression that his ideals were very conventional. He intruded constantly on his mother's privacy.

At the time of his referral the family was living with the maternal grandmother. The mother disliked her mother and the patient got along very poorly with his grandmother.

The patient's conception was an accident and the mother was very angry when she discovered she was pregnant. Her health was good throughout the pregnancy. The use of high forceps at his birth resulted in a temporary partial paralysis of the right side of his face. He was circumcised while in the hospital and screamed continuously for twenty-four hours after the operation, in fact, he screamed almost constantly for the first six months. He was breast-fed for six weeks and there were no weaning difficulties. His mother stated that his bowel training was completed by the age of five months and his bladder training by eighteen months. Following this he was constipated and was given many enemas. When he was two his sister was born and he exhibited great resentment toward her from the day she was brought home. He had a tonsillectomy and adenoidectomy at the age of two and one-half and the mother could not come near him for several days after the operation because the smell of the ether made her ill. At three he was started in nursery school. Between three and five the father tried very hard to estrange the child from the mother. When the parents separated the mother took the children to live with the paternal grandparents. The next year she employed a very strict governess and during this regime the patient's social attitude changed from shyness to poise. At seven he had a severe attack of pneumonia. In fear of recurrences he lived with his mother in Arizona and Florida. At ten he developed insomnia because he was afraid of his dreams.

The patient's capacity to use his learned knowledge successfully was inhibited by a sense of guilt and need for punishment. In order not to feel guilty he had to inhibit his desire to learn and in order to assuage whatever feelings of guilt he suffered he had to punish himself by failing. The sense of guilt and the need for punishment indicated the presence of a very severe superego of a primitive type. This primitive severity was caused by three factors. The father actually had been a cruel man. The patient had been absent from his father since he was five years of age, so that there had been no opportunity for him to

modify his oedipal fantasies of the father's cruelty by comparing them with the real father. Because of this separation there had been no father with whom to identify himself. His school failure served to avoid the punishment at the hands of his superego.

His sense of guilt and unconscious need for punishment arose from his ego fear of the superego's resentment against his marked unconscious incestuous attachment to his mother. If he was successful in accomplishing his ambitions and in pleasing his mother by learning knowledge and skills he might be able to possess her, he dreaded this lest it result in his castration and death at the hands of his fantasied cruel father.

The unconscious need for punishment caused him to project his superego onto external authorities whom he, so frequently, actually induced to punish him. Part of this need for punishment by an external authority was an expression of a passive longing for a firm consistent father who would prevent him from getting into trouble when he acted in ways that actually were forbidden. This passive longing for a father was increased by his fear that if he possessed his mother she would send him away, as she had done with his father. He felt that if he took his father's place he would be punished by ostracism. His passive longings were further increased also by his desire to be a girl in order to be favored by his mother as his sister was. This again interfered with his ability to learn because if he learned he would be more masculine and so would not be favored by the mother.

His capacity to use his learned knowledge also was inhibited in order to express his spite at his mother, who wanted him to learn, for favoring his sister and for sending his father away.

Desiring his mother's love he endeavored to circumvent the severity of his superego by an unconscious fantasy. If he could be a girl then his mother might love him more. His masculine pride revolted at this idea because it entailed castration, so he had to regress to another unconscious fantasy, that of being a baby. This unconscious wish to be a baby interfered with his ability to learn. The regression was mostly to the anal sadistic stage, although there were oral elements and it indicated that he had accepted the idea of being a girl. He had identified himself with his mother and sister, but at the same time he was able to retain his penis. Now his orientation was to have a penis but to be passive and masochistic to men, i.e., to external authorities, in a passive anal way. This anal passivity also interfered with his ability to learn which is an active process. Consciously of course he reacted violently against his strong unconscious passive masochistic desires but his reactions were of the kind that again would gratify his passive masochism. They were antisocial and caused the external world to become punitive toward him. This indicated again that the conflict had regressed from the phallic level, where learning represented the successful use of the penis to the anal sadomasochistic level where learning could be disregarded because the only importance of the penis was its possession not its use. He possessed knowledge but he did not use it.

In this case the use of learned knowledge, which in the unconscious represented the use of the penis, was inhibited. This defense was not sufficient to

placate the primitive severity of the superego, hence a regression to the anal sadistic level had taken place. The superego would not tolerate the sadism at this level, because it represented the phallic activity before the regression took place, and so still was connected with the use of learned knowledge. As a further defense the active sadism had to be changed into passive masochism. He now unconsciously would be a girl and a baby and demonstrate he had no capacity to use learned knowledge. Still he would possess knowledge which unconsciously no longer represented a penis but the feces of the little child.

In the cases where there is a disorder of the use of learning accompanied by regression and acceptance of castration the history of earlier severe phobias which have disappeared due to the substitution of the inhibition of the use of learning for the phobia mechanism is not found. It appears as if the inhibition of the use of learned knowledge was a sufficient defense. The further defenses of regression, changing activity into passivity, sadism into masochism with the acceptance of a passive masochistic orientation, i.e., of castration, have to be introduced. Against this unconscious orientation the masculine pride of the patient struggles. The passive masochistic orientation forbids the active use of learning and so a second inhibition of the use of learning results.

In Case 24 and in other cases of this type the regression to the anal sadistic stage does not seem to have been followed by the secondary defenses of an obsessional neurosis. In the Wolf man there was an inhibition of learning as part of a character disorder resulting from a remission of an obsessional neurosis, and Freud (1918) points out that an obsessional neurosis may recover or remit and be followed by a decrease in the ability to learn. From Freud's case it might be argued that my patient's primary illness might be an obsessional neurosis with regression from the phallic to the anal sadistic stage. The obsessional neurosis would be of a severe type in that not only was there regression but activity had been replaced by passivity, sadism by masochism and any phallic strivings by the acceptance of castration. In order to maintain the passive masochistic orientation, an inhibition of the use of learning occurred secondarily. It is difficult to decide in these cases whether the inhibition in the use of learning is the final result of a remission of an obsessional neurosis, or whether, as I have described, the capacity to use learned knowledge itself is involved in the unconscious fantasies of the neuroses. This may be true also of the cases in which there is a disorder of the use of learning without regression. In the latter the disorder of the use of learning is not accompanied by much regression but is an inhibition which seems to be the result of an attempt at self-cure of an anxiety hysteria. The symptoms of anxiety hysteria have been controlled and replaced by

inhibitions falling on the capacity to use learned knowledge and by changes in the character.

I believe that the cases I have described are character neuroses, consisting of the defenses of inhibition and ego restriction, and are not the result of a remitted obsessional neurosis. It may be that there are really two varieties of disorders of the use of learning accompanied by regression. In one there is first an obsessional neurosis, the acute stage of which recovers by producing a decrease in the ability to learn and character changes which are the result of an attempt at cure. In the other, no acute obsessional neurosis occurs but the capacity to use learned knowledge becomes involved in the regression and the associated mechanisms, along with character alterations, and any obsessional symptoms which occur are secondary.

In my cases, the regression has caused the concept of the penis to be replaced by the earlier concept of an anal penis. This concept is regularly associated with another, i.e., that sexual gratification is obtained through a fight in which one partner, the male, masters, hurts and destroys the other, the female. The use of knowledge through the regression becomes associated with the anal penis and therefore the pleasure in its use becomes a sadistic pleasure. This is well illustrated by the following case.

Case 25. An adult man, highly intelligent and highly educated, spent a great deal of his time as an adolescent and as an adult in acquiring information, most of which was totally unrelated either to his school work or to his profession. There was practically no field of knowledge in which he was not almost an authority—unless it related to his work. In this field his knowledge was woefully defunct, in fact, he almost refused to read literature necessary to his profession. He consistently used this unrelated knowledge at social gatherings for the purpose of making other people feel foolish and ignorant. He did this so successfully that most people at the party disliked and resented him and did not want to meet him again lest they have their feelings hurt. As a child he decided never to allow himself any conscious emotional reactions or feelings. Instead he decided only to think and learn. He tried to sublimate his sadistic feelings, but the mechanism of sublimation failed and his colleagues perceived, and were affected by, the expression of his partially sublimated sadism and quickly came to resent and dislike him. Here the use of knowledge gratified his exhibitionism and his real sadistic perversion as well as reassuring him that he really was masculine.

This patient did not fear his sadism as the patient in Case 24 did. In the latter case the patient felt very frightened and guilty about his sadistic impulses and therefore had to change his desire to use knowledge in a sadistic way into a masochistic apparent lack of knowledge. In some cases

this apparent lack of knowledge may make the child appear almost feeble minded in the use they seem to make of their knowledge

All of these patients who have diminished capacity in the use of knowledge show also a lack of ambition. One of the sources of ambition is a sublimation of urethral erotism. If this sublimation fails the individual is not as ambitious as he otherwise could be and an interference with ambition disturbs the need and desire to learn

Case 26 A fourteen and a half year-old boy was referred because of poor school work which the teachers believed to be due to an immature irresolute and irresponsible attitude. He was inattentive in class and had a lackadaisical attitude. School grades in all subjects were barely passing in spite of the fact that he had an IQ of 121. When he first started school he thought of it as a game and was extremely fond of his first grade teacher. At the end of the half year however the teacher whom he liked left the school and the subsequent one was a stern disciplinarian who taught subjects not children. At this time he developed a dislike for school and began to have marked enuresis both diurnal and nocturnal. At this point because he could not solve the problems in his relationship with his father successfully he regressed from the second to the first phallic stage and was unable to maintain his sublimation of his urethral erotism. With the failure of this sublimation his ambitions and his ability to learn decreased.

Frigidity in the female is the equivalent of impotence in the male. The impotent male dreads his active aggressive sexual impulses and so inhibits the genital functions through which he normally would express them. The aims of the sexual impulses and the genital functions by which the woman normally would express them are inhibited in the frigid woman by the inhibition of her orgasm with more or less anesthesia of her genitals for pleasurable sensations. Therefore the inhibition in the case of frigidity falls on the pleasure of the dreaded passive receptive impulses. The dread is of the active aggression in the feminine passive receptive desires. The frigid woman is afraid unconsciously that she will be injured by the penetration of the penis or that she will injure or destroy her partner's penis and in turn will be punished according to the talion law.

When the ego functions of learning and of using the knowledge so obtained is equated in the unconscious with the passive receptive vaginal desires they will be inhibited if these are feared and the girl will not learn lest she find herself a grown up and capable woman. In the previous section where I have discussed disorders of the use of learning I have been discussing the problem as related to boys. However I have cited several illustrations where the patients were girls. In these illustrations the inhibition fell on the active aggressive desires. In the cases I

am about to discuss the inhibition falls on the really feminine impulses.

Case 27. A girl of fourteen was referred because she was in danger of being suspended from school, partly for her behavior and partly for her lack of scholastic progress. She refused to conform to any of the rules set by the Student Council. She had thirty-five demerits in one month, a number no other student of the school ever had. She chewed gum in class, wore red nail polish, giggled and passed notes. She failed Latin and French and physical education, the latter failure was due to her refusal to take part in competitive games.

She always had attended the same school but her school failure began when she entered the Junior High School department, so that her present problem seemed to have been precipitated by the onset of puberty. I have discussed earlier this etiological factor in scholastic disorders.

Her Rorschach examination showed that she had a moderately superior intelligence. The complete report was as follows:²

The girl was quite friendly from the outset and co-operated well, showing a good amount of interest in the test. Apart from a manner which was perhaps a bit too quiet, conformed, and lacking in spontaneity for one of her age, I noted no abnormalities of behavior during the time she was with me.

The Rorschach reveals a serious degree of withdrawal and regression, with concomitant intellectual dysfunction. It appears that she possesses basic mental capacities of at least average caliber, and more probably in the range of moderate superiority. There is much fluctuation, however, in level of intellectual function. She indulges in a great deal of fantasy and makes no effort to use logical control over this, so that her thinking is often totally unrealistic and illogical. When given a second chance, her performance is unpredictable. Sometimes she is able to improve her concepts considerably under pressure but again becomes even more hopelessly confused. She has inadequate interest in the practical and concrete aspects of everyday living and little regard for the obvious. She finds it quite difficult to think along the lines of other people, her thinking being quite unconventional and original, in a far-fetched way. In view of all this, her failure to achieve in school is readily understandable.

There is not much by way of neurotic structure observable in the record, the girl showing no disturbance in the face of either emotional or sensual stimulation. However, some compulsive tendencies are evidenced in her need to see things as a whole, to put things together even when this makes an illogical idea necessary, or introduces irrelevant elements into otherwise satisfactory concepts. (Possibly associated with a desire to unite her family?) When confronted by stimulus material with sexual implications, she overlooks these implications entirely, in a way characteristic of the latency period rather than of adolescence. A number of her ideas are distinctly in-

² I am indebted to Miss Eleanor Ross for this report.

fantile in nature, being of a type frequently encountered in records of pre school children

The content of the Rorschach is meager and does not offer much toward definition of any specific conflict area. It may be of interest to note however, that all female figures originally seen are caricatured or seen as rude gross and ugly, but that under pressure she is able to adopt a more favorable attitude toward women. In the performance proper male figures are avoided entirely. When asked specifically to look for men the girl sees three: first a cross-eyed Viking with a long beard, next a king with his hands raised in dismay at receiving bad news, perhaps that his army has been beaten, and finally a green gremlin with terrifically long arms reaching out in front of him to sweep in his gold. The last two concepts as related to the actual formation of the blots are in a degree unrealistic and confused, giving indication of serious disturbance on the girl's part with regard to her relationships with the father or father figure. In spite of the severe degree of disturbance present, which is markedly schizoid if not actually psychotic in nature, the prognosis does not appear entirely unfavorable. She has a considerable degree of sensitivity and capacity for forming emotional relationships with others, which should make a good transference possible. She has good intelligence and under pressure can be induced to think on a more realistic basis than when left to her own devices. Finally the presence of some neurotic compulsions may make her more available than if there were no such defense. Without intensive therapy however, it seems most likely that a schizophrenic break will occur sooner or later.

At home the patient showed an inability to conform to household routines, she was late for meals, objected to going to bed, and would not admit when she had made a mistake. She tormented her younger half brother. She seemed to be completely indifferent to the feelings of her mother, her stepfather, and the servants. She also seemed to be indifferent to matters that concerned herself. She was unconcerned about a weight gain of seven pounds. Although she said she loved animals, she seemed to be totally unconcerned with her dog of whom she had been very fond, was killed by a car. She only expressed the hope that she would get a new dog soon. She did feel sorry when her stepfather suffered a sudden attack of coronary disease. She had a rather prim and proper attitude. She disliked the cocktail parties which her mother attended and gave was not interested in radio and in religious ritual. Although her parents were not religious, she was ashamed of her menstruation, particularly she did not want her stepfather to know about it. She was mildly untidy in her habits. As a smaller child she was embarrassed when praised. If she anticipated that she would be in trouble for something she had done or if she anticipated that a difficult situation lay ahead, she used her charm to get out of the trouble or to handle the difficulty.

She had a few girl friends but selected those who already were rather antisocial and liable to get into some kind of trouble.

The mother was the daughter of wealthy parents. The grandmother was an

alcoholic. The mother had run away from school at seventeen, married, had a son and then divorced her husband, who suffered from manic-depressive psychosis. She then remarried an alcoholic irresponsible man, whom she left when the patient was five. She remarried when the patient was seven and had another child. The mother was afraid that the patient would be like her father and like herself and had warned the patient about this, inculcating by *precept* fear of men and a sexual life. Actually the patient lived a very unrestricted life, observed considerable drinking by both her mother and maternal grandmother and had attended numerous drunken parties.

The father, although intelligent, had had a great number of positions and was usually changing from one position to another. There had been long periods when he had been unemployed. He had remarried twice since the patient's mother divorced him. His second marriage was to an alcoholic woman, who had a daughter about the patient's age. The patient had visited with her father during the summer and frequently had seen the father's wife and the father very drunk. The father's third marriage introduced many new relatives into the patient's life.

For a while the patient was solely in charge of an indulgent but strict governess who left when the patient was ten. During this period the butler seduced her. After this butler left, the next was a paranoid alcoholic. The patient was devoted to his wife and put her in place of her real mother. The patient's mother had trouble with the butler's daughter who ran away to Hollywood and the patient was imitating her. The succession of marriages and divorces in the family had left the patient markedly confused as to her actual relationship with the new and old members of the family. Besides this confusion, the patient also had many problems of interpersonal relationships. There was sibling rivalry with her younger stepbrother who had a character neurosis. Her stepfather preferred his own son to the patient. The patient disliked the stepfather because of her unconscious attraction to him. Her mother preferred the younger stepson. The patient was devoted to her father. She idealized him and she felt he was unfairly treated by her mother and by the community in which she lived.

The patient's outstanding presenting symptom was the fact that she appeared to have no feeling for objects, no regard for her stepfather and mother, stepbrothers, dog, etc., and little regard for herself, e.g., her weight. She consciously fostered the attitude of having no feeling by refusing to admit what she had seen and heard about her father, his wife and stepdaughter and to a less degree about her own home. At times this refusal to admit the evidence of her senses reached the extent of true denial. She denied in order not to feel. This indifference in feeling was reinforced by her prim and proper ideals, her embarrassment when praised, her interest in religious ritual, not in cocktail parties and her embarrassment about menstruation. The fact that she was so modest with her stepfather about her menstruation, that she did show a slight concern over her stepfather's coronary attack and that she did like animals, showed that she really had an ability to feel but when her feelings were increased, e.g., if something happened to the animals about which she had real feeling, the indifference

returned. It was replaced by an attempt to charm if she looked ahead or if she found herself in trouble.

Underneath the superficial lack of feeling lay a confused hotbed of conflicts between her real feelings and her fears and feelings of guilt. Although she disregarded male figures in her Rorschach when asked specifically to look for them, she saw frightening ones. Also, she had a definite heterosexual life. She preferred her own father. She was angry at and feared her stepfather because he playfully grabbed at her as he did at her mother. She was afraid of being too intimate with him, even asking him for her allowance was too intimate for her. She had several boy friends, who were selected as a reaction against her mother's extreme snobbishness, but she had to be 'good' with them. She feared sexual relations with boys but in order to prove that she was not afraid she permitted even genital touching. She developed a realistic fear that she would lose all her boy friends because she would be thought, and might be the type of girl who led boys on and then dropped them. (This was an identification with her mother who had three husbands.) Her masturbation was without orgasm but with fantasies of being nude with a man and of sex play without intercourse. A dream in the transference situation showed her fear of genital penetration. She consciously feared getting married lest her marital life reproduce her mother's which had caused her mother and herself so much suffering. Her fears of sexuality were combined with phobias of cancer of the mouth of lightning and of water. She copied her mother's fear of polio.

Her heterosexual drives were all combined with hostility to her mother. She complained that her mother interfered with her activities. She was very envious of her mother's clothes and money, which she complained that her mother spent mostly on liquor. She was irritated by her mother's shiftlessness and desired that her own routines be better than her mother's. She herself was untidy in her habits but could not sleep if her room was untidy so that part of her defenses against her mild anal regression were used to show up her mother's shiftlessness. She accused her mother of lack of supervision (this was true). There were constant battles with her mother over the length of her phone calls. She felt guilty about her hostility. She was afraid of me because I might tell her mother about her. She feared me because she felt disloyal to her mother in discussing her with me although she did not feel so disloyal in discussing her mother with the cook. One day she dyed her hair, against her mother's orders and did not do her homework. The next day she went to school without her glasses and developed a headache. After a series of accusations directed at her mother (e.g., that her mother had no confidence in her, that her mother lied and exaggerated) she felt she was no good, always left out and not wanted, particularly by her mother. I got the impression that an attack of illness was partly induced to punish herself for a quarrel with her mother. The illness increased her dependence on her mother, her self-accusations about the way she treated her mother, her liking for her mother, particularly if her mother liked me, her hostility to her stepfather. It also changed her love for her stepfather into pity. She was very unhappy when her mother broke her arm because then she felt unloved. She disliked her boy friend because she said that if she liked her mother he teased

her When she was able to accept her dislike of her mother, she clung to her love for her paternal grandmother

The patient's superficial difficulty was her lack of feeling to which she added her own denial of sensory perceptions The lack of feeling and denial was based on her frequent disappointments by her father, her mother, her nurses and her governess and on her apprehension of the future due to her fear (desire) lest she repeat her mother's marital life and her fear (desire) of injurious penetration of her body The disappointments caused her difficulties in her object relationships She was furious at her father because he disappointed her, and part of her refusal to learn and her naughty behavior was an expression of her unconscious wish to spite him If she was unsuccessful at school she would remain a child and therefore he would have to look after her She said she felt sorry that he had to spend so much money on her Her poor school work was a passive receptive demand for his help and love She was furious at her mother for not loving her more To this fury was added her basic hostility and her envious jealousy of her mother and her possessions Her poor school work was an expression of unconscious spite against her mother Her fear (wish) to repeat her mother's marital experience and her scholastic life was also an expression of hatred She felt guilty about this combined hatred and assuaged her guilt by a rejection of heterosexual objects such as her stepfather by her physical illness which was a self punishment for her hatred of her mother and by her attempt to find a mother substitute teachers cook paternal grandmother etc Her poor school work was a self punishment as a means of assuaging her guilt about her competitive hostility to her mother She longed for her mother's love This was a very strong unconscious component of her problem Her desire for her mother's love caused her to feel guilty about her hostility to do poorly in school in order not to surpass her mother who never finished high school and to do poorly in school so she would remain her mother's baby She reacted violently against her passive receptive desire for her mother sexual in nature by over accentuating her heterosexuality Her passive receptive desires were increased by her disappointments and her conscious fear (unconscious desire) to repeat her mother's unsuccessful scholastic and marital life

Her passive receptive wishes were her most important unconscious problem She reacted against her exhibitionism and her desire for pregenital (forepleasure) gratification by self punishment She would make people look at her through her naughty behavior and failures rather than through her assets and she would make her mother cuddle her by being a failure As soon as her father manifested interest in her took her from her mother and put her in the boarding school of her choice her work and behavior improved

Her school failure was an effort not to be successful a neurotic inhibition in the use of her learned knowledge which represented her passive receptive feminine desires which she feared and repressed She suffered so to speak, from educational frigidity I believe this was the most important factor in her diminished capacity to use learned knowledge In this conclusion I disagree with the findings of the Rorschach which considered her disturbance schizoid and probably prepsychotic with some compulsive defenses on the basis of the fact that

she showed that she had inadequate interest in the practical obvious and concrete, that she showed no disturbance in face of either emotional or sensual stimulation that her logical thinking was replaced by fantasy which made her thinking unrealistic and illogical that she had a slight tendency to paranoid projection and felt she was persecuted (however there were some real reasons for this feeling) and that there was evidence of compulsive tendencies. According to this evaluation her learning problem would be the result of her denial of external concreteness and practicalness and the replacement of the denied impressions by fantasy so that the perception of real material and of fantasy constantly fluctuated. Thus her learning difficulty would be caused by a combination of a defect in her ability to test reality and by a disorder in the digestion and assimilation of the learned material.

I do not think that this was the main cause because clinically she showed that she had the capacity to form relationships and to be influenced by another person so that she actually lacked the narcissistic cathexis of psychosis. Her marked disturbance of object relations both with men and women had resulted from her denial of perceptions in order to deny her very painful feelings if she allowed herself to perceive the facts. Added to this the main cause of her learning difficulty the neurotic inhibition in the use of learned knowledge which represented her feared passive receptive feminine desires there was a slight deflection of attention from her school work to her fantasy life and intrapsychic conflicts and a mild disorder in assimilation of ingested knowledge as appeared in her Rorschach examination. She also had a mild difficulty in taking in knowledge. Her denial of sensory perceptions induced a slight difficulty of oral ingestion. She could ingest food but had difficulty in sublimating her oral ingestion to take in intellectual knowledge.

In the cases of boys who have diminished capacity to use learned knowledge there is an inhibition of the use of knowledge because in the unconscious it is equated with the use of the penis. In girls the use of learned knowledge may be inhibited because it is equated with the use of the vagina. They are afraid that their genitals will be injured if they admit their feminine role (In this they are behaving as the counter part of the boys whose learning difficulty lies in the fear that their genitals will be injured if they use their knowledge). They are ashamed of their penisless state, which increases their dreaded passive receptive wishes. They feel they are defective as compared with boys and strive to overcome this feeling by enhancing their passive receptiveness which they dread for reasons I have mentioned earlier.

Children who show an inhibition of the ability to use learned knowledge usually can be diagnosed and treated only by a psychoanalyst because their cure depends on making their unconscious conscious. Their illness is not amenable to any educational measures.

B. Diminished Capacity to Learn Due to Disorder in the Function of Taking in Knowledge

Curiosity, the desire to know by seeing, hearing, touching or any avenue of sensory intake, is an important basis of learning. Its pleasure value is a displacement onto the sensory organs of the pleasure and utility value of the desire to take in by the mouth during the oral intaking phase of psychosexual development. This process of displacement can be seen in the fantasy that underlies the learning difficulty in Case 20 cited above. If, for any reason curiosity or the concept of intaking produces pain instead of pleasure, the curiosity will be inhibited and the individual will have some difficulty in learning. The inhibitions may fall on certain specific processes.

Case 28. The teacher of a girl of twelve years of age noticed that almost invariably after some instruction to the class the patient would come to her and ask what the instruction was. Further observation revealed that the patient seldom heard anything said to her. Hence little auditory learning took place, although the patient certainly was not deaf. This symptom appeared not only in classroom situations but also during ordinary conversation. Study of this situation revealed that the patient's mother was a very verbal and voluble individual, who scolded a great deal and often made statements which were contradictory one to another or with the obvious facts. This behavior of the mother often made the child angry or more often made her feel that her mother did not love her. The feeling of not being loved was very painful to her. She knew also that the mother would be angered if she became angry. Therefore the girl learned gradually to avoid these reactive feelings to the mother's tirades by closing her ears to what her mother was saying and to think about something else. Very soon this reaction became automatic and she found herself not hearing much that was said to her. Here the apparent deafness, i.e., an inhibition of hearing, occurred for the purpose of avoiding the arousal of unpleasant and dangerous feelings in herself. It had the added value that it forced the mother to repeat what she had said. In this way the patient was able to gratify her desire for her mother's love by attracting her mother's attention to herself.

Case 29. An adult man in analysis had a dream which involved an old battered bat. His associations indicated that the dream concerned the analyst. When the analyst acquainted him with that fact, the patient denied ever having seen the analyst's hat, which in reality had lain on the window sill in full view of the patient every time he entered and left the office. Later a matter of arrangement of the analyst's office space was discussed and the patient, although he had seen this arrangement for several years, had a mental picture entirely different from the real one, the differences consisting in the omission of a number of important details so that his mental picture bore only the slightest resemblance to the real facts. He had happened to meet the analyst once sometime before the analysis began. In his memory of this incident he had substituted another

person with certain marked character traits for the analyst and from that time forth regarded the analyst as being exactly like that other person. In all three situations even after being confronted with the real facts the patient still persisted in his imagined alterations of reality. As a child he had slept in his parents' bedroom until about the age of six. He knew of this from his mother's and sister's statements but had no personal memory of it. Although memories appeared in his dreams he repudiated them. His fairly successful life was based on a very restricted inhibited character pattern which was the result of many similar falsifications of realities. These falsifications of things he saw was aimed at avoiding the recognition of emotions and feelings in other people lest he have emotional reactions. The pattern had come into being in order to avoid his feelings and wishes aroused by the recognition of parental intercourse which he saw many times. This technique of denying sensory impressions caused him to falsify reality and to react to these falsifications as if they were real. This interfered with both his ability to learn about new situations and to profit by the increased experience of adjusting to them.

Although all of us tend to perceive a new situation as if it were a replica of previous ones and so distort some of our new perceptions we do not make ourselves as completely oblivious to the major details of the new situation as this patient did.

Case 30 An adolescent girl of fourteen frequently flunked her examinations in school because she did not know the answers to the questions. Consciously she truthfully denied any of this knowledge but at frequent intervals in her conversation she would give the correct answers. When this was pointed out to her she would repudiate her knowledge protesting it was only a guess and that she really could not learn. Her school failures were motivated by the reasons I have discussed already under the use of education but the phenomenon I am now describing was different. Her parents denied to her the existence of certain situations and actions that went on in the home and became very angry with her if she mentioned them, telling her that she was not telling the truth. Particularly was this true during her late prelatency years and during the latency period. In order to be on good terms with her parents she accepted their statements and solved the conflict about reality thus aroused in her mind first, by denying her sensory perceptions and second by repressing them into the unconscious. She followed this shortly by repressing each not wanted sensory perception into the unconscious before she perceived it consciously. As is usual with a defensive technique it began to manifest itself in other situations where it was not needed and her ability to learn suffered. The knowledge was in her mind but it was kept repressed from consciousness just as the knowledge of the home situation was repressed from consciousness because of the painful feelings associated with it.

In these three cases the learning difficulty was the result of inhibiting visual and auditory perceptions in order to avoid painful feelings. In the last case however, it was not only inhibited to avoid painful feelings but

also to please the parents, so that this case serves as the link to the next group of reasons for difficulties in learning due to the disturbance of the capacity to take in knowledge.

As I mentioned earlier the pleasure value of curiosity is a displacement to the sensory organs from the pleasure and utility value of the oral intaking phase of psychosexual development. The interests of the very young child are centered about his own body and the bodies of other people. His curiosity can be called sexual curiosity, perhaps physical curiosity would be a more accurate term. Later the curiosity is changed from its limitations to physical and sexual phenomena to a curiosity about all the phenomena of the world, both internal and external. It is sublimated. If the child's early curiosity leads him to observe factual realities, which, to him, are revolting, such as the sight of the female genitals for the boy or the sight of the male genitals for the girl, there may develop a more or less complete inhibition of curiosity depending on the degree of the child's reaction. Similarly if the observation arouses very strong erotic or hostile desires in the child (desires which he feels unable to deal with) such as the sight of the size of the father's body and genitals as compared with his own or the observation that her mother has breasts or pubic hair, both of which the little girl lacks, an analogous inhibition of curiosity may take place. It is such situations that cause all children to inhibit, to some extent, the pristine curiosity of early childhood by the time they reach the age at which they begin academic studies in school. Only the very occasional person retains even the greater part of his early childhood curiosity.

If the early physically directed curiosity receives disapproval or punishment, the child, in order to avoid the feeling of displeasure, will inhibit his curiosity so that only a portion can be sublimated. The extent of the inhibition will depend on the severity of the disapproval or punishment.

The psychic faculty of curiosity is closely related to the psychic mechanism of incorporation. I do not know whether it arises as the result of the transformation of part of hunger and the need to ingest food into a psychic faculty or whether its development follows the course of the transformation of part of the physical need to eat into the psychic mechanism of incorporation. In either case it is an ego function, as incorporation is, and is affected by the same vicissitudes which may affect the mechanism of incorporation. I have mentioned the great importance of curiosity for the learning process and how the latter is injured if the gratification of curiosity has to be renounced directly. Curiosity can be injured indirectly also if adverse influences affect the mechanism of incorporation. Incorporation is the psychic counterpart of the infant's oral

desires—to be fed when hungry, to suck, to get pleasure from putting articles in his mouth, to possess by holding in the mouth or swallowing etc. If these physical needs and their oral means of gratification have been either stimulated excessively or inhibited by fear or pain, the ability to incorporate psychically will be affected adversely.

Case 31 A high school student in her late teens showed a striking amount of amnesia for school knowledge. Although she had good intelligence she was failing in all her subjects. Consciously she felt that she was very ignorant and in her conversation appeared to have only meager knowledge of history, English, foreign languages and mathematics. From time to time her real knowledge appeared in her dreams. Her analysis gradually revealed the fact that instead of being ignorant she really had a good store of knowledge. Her problem was the reason why she could not remember consciously what she had learned. This stemmed from several sources.

As a little girl her mother had insisted that the patient tell her everything she thought and did. In order not to lie, which to the patient was a great sin, she conveniently forgot much that she did or thought when not with her mother, particularly those things which she knew would make her mother unhappy or angry. Then she could report to her mother with a clear conviction that she was telling the truth. This mechanism got beyond her control (for reasons I will mention later) and began to affect even the memory of her school work.

She had very strong but unconscious wishes to be a weak, helpless baby dependent on her mother. These wishes appeared in her dreams and in some of her behavior and had been stimulated by her mother's engulfing love and her early sexual stimulation of the patient. They forced her to repudiate any hostile feelings for her mother. The mother had increased this need to repudiate any hostile feelings at the height of the oedipus situation actually by handing over the father to the daughter.

These two problems, the unconscious wish to be dependent on the mother and the intense feelings of guilt about any hostile feelings toward the mother, interfered greatly with any desire on the part of the patient to be an adult, intelligent woman. Moreover, the patient's concept of femininity was to be sick, incapable, infirm, injured and subordinate, i.e. penisless. To her, her ignorance was one expression of femininity.

In order to solve these conflicts she allowed herself to take in the knowledge she acquired in school but repressed it immediately so that she could not use it or admit to herself that the use of this knowledge could be satisfying and pleasurable. The scholastic difficulty at this point seemed to be a problem of the use of knowledge but this conclusion raised another question: Why did she incorporate the knowledge but this conclusion raised another question: Why did she plish the same purposes by not taking it in at all?

She also complained of a mild compulsion to eat which later in analysis changed to an intense hunger for knowledge. For the first three or four years

of her life she had been a marked feeding problem and several times had nearly died. When the desire to incorporate orally appeared in the analysis the patient experienced painful sensations in her body resembling the pains of starvation. These sensations were felt as physical and not as psychic feelings and she dreaded them because of their unpleasantness and because they were connected with feelings of hatred for her mother who often had told her that she the mother was responsible for the child's feeding problem and her closeness to death because she had fed her improperly. The patient felt very guilty frightened and remorseful for hating her mother.

In this patient's case the intense need to devour in order not to suffer again the pains of starvation was inhibited lest she devour her mother and so destroy and lose her. Her starvation had stimulated her oral aggression. The ordinary person does not have the same degree of oral aggression against the object as this patient did. In him restitution is made for the destructive elements in the desire to incorporate orally by the development of memory. Permanent traces of the destroyed—because incorporated—object are laid down in the cortical association pathways and these permanent traces are considered psychically to be parts of the object. As the traces can be revived as memories the destroyed parts of the object can return from destruction and become alive and whole again. The greater the ambivalence to the object the less possibility will there be of remembering the parts of the object incorporated through hate. In my patient the degree of ambivalence to her mother was very great and every desire to incorporate had both a strong desire to retain and keep the object and a very strong desire to destroy the object. In order to keep the ambivalence to her mother unconscious she had to repress a great deal of knowledge which she had incorporated.

In this patient there was an excessive need for oral incorporation based on the organic memory trace of the infantile starvation experiences. This excessive need was feared because she dreaded the results of its gratification i.e. the loss of her mother. She therefore inhibited her desire to incorporate knowledge lest she suffer the painful feelings and emotions I have described but her need for psychic oral gratification was so great because of the infantile starvation that she took in the knowledge automatically but kept herself consciously unaware that she was doing this or of her possession of the knowledge.

Ungratified excessive oral needs in infancy and the fear of the results of oral gratification often will affect the future learning ability of the child. Another result of such a conflict may be a simple inhibition in taking in knowledge.

Case 32 A twelve year-old boy whose intelligence and whose musical ability were very great was referred because a dispute had arisen between him and his music teacher. His IQ was 166. At the age of ten he had been selected as one of the greatest child violinists and a pianist of distinction. He wanted to play the musical works he was studying in his own way which he said and felt was more truly musical than the way in which the composer wrote them or the way

in which his teacher insisted they be done. As a result of this the patient was refusing to practice. His refusal was jeopardizing the scholarship under which his musical training to be a concert musician was taking place. His musical education had been paramount in his life so that he had not attended the usual schools but had been tutored or had attended special half-day classes. His educational achievement was slightly superior to other boys who had had the usual school experiences.

It is not necessary here to describe and discuss a number of personality problems and their dynamics which this boy showed. An important element in his desire to do things his own way and his refusal to accept his teacher's and his mother's advice was revealed in a dream.

He dreamed that cannibals came into his home and started to devour his sister while his mother, his father, his grandmother and he hid between the springs and mattress of his bed.

In this dream the patient expressed his hatred of his sister. This hatred was conscious so that it was curious that he had to dream about it and also to dream about it as a projection. The hatred directed to the sister in the dream was displaced from the mother, father and grandmother, all of whom he protected in the dream text. He was not aware of this hatred in his waking life. He protected himself from knowledge of his feelings to them by his general inactivity. This inactivity was a punishment for his guilt about his sexual desires for his mother and his competitive hatred of his father. It not only protected him but it also was a means of expressing unconsciously his spite at his mother for her restrictions on him and for depriving him of the babying care she gave him as a small child when she weaned him and when she bore his sister and of his oedipal hatred to his father. He showed some regression to the anal sadistic stage of development by his interest in maps, cataloguing and collecting, by his personal untidiness and disorderliness and by his reaction formations of unwillingness to take exercise, stubbornness and rigid independence. Through this regression he was able to get his mother and his father to nag him. He consciously disliked this but unconsciously it gratified in a passive masochistic way his unconscious sexual love for his mother and his desire for his father's love.

His learning difficulty partly was the result of his character traits. More largely it resulted from the inhibition of his devouring oral aggression. His tendency to eat up those objects whom he loved and whom he hated had to be inhibited lest he suffer the punishment (and gratify his unconscious desire) to be eaten up himself. The cannibals in the dream represented oral hatred. The displacement from his parents and grandmother to his sister did not suffice to defend himself against the fear of retribution in kind so he had to project it. The severity of oral hatred was the result of the fact that he was breast fed only for three months and after he was weaned from the breast he became a feeding problem.

This inhibition of his oral aggression prevented him being able to learn from his parents or from his teacher for if he responded to them either with love or hatred he would eat them up. He preferred therefore to do things his own way so as not to be in any close emotional relationship with them. He did not

have amnesia for what he had learned but he inhibited his desire to take in and to learn because of his dread of the unconscious fantasy of devouring and being devoured

Under the stress of a different fantasy the ability to take in knowledge is not inhibited but actively repudiated

Case 33 A boy who was a senior in high school complained of his inability to study. He postponed starting studying as long as he could by reading magazines and papers or by doing little chores. Often these activities used up all the time he had to study. If he finally began to study he found it difficult, if not impossible to keep his attention directed on what he was reading. If he could keep his attention riveted on his book he found it difficult if not impossible to understand what he was reading. He did not deny his desire to learn as do so many cases of high school failure (which denial makes an added difficulty in treatment) but being a highly ambitious and competitive person really was concerned about his inadequate school progress.

He already had begun a fairly regular sexual life. On several occasions he found that if he really studied he would be impotent while if he did not study he would be potent.

One motivation of his difficulty in learning was his unconscious wish to be unsuccessful. This solved his unconscious conflict about his father. Consciously he was driven by a wish to surpass his father whom he despised whom he feared but whom he loved unconsciously to a higher degree than ordinarily because his father was indifferent to him and because his mother's attitude to the patient made him turn more to his father whose indifference was not so painful as her behavior was. She was very inconsistent encouraging his ambitions to do better than his father and at the same time telling him that learned successful men usually became atheists.

The more important fantasy that caused him to repudiate his ability to take in knowledge appeared in connection with a male teacher. He developed a strong conscious repudiation of everything the teacher said because he felt that all the teacher did was try to shove ideas down his throat. If these ideas were shoved down his throat he would be like a goose being fattened for a holiday dinner. In this fantasy he defended himself against his strong passive receptive oral desires toward a man and to his father by projecting them onto the teacher and by changing them into active desires the teacher was *shoving* his ideas down the patient's throat. Here there was active repudiation of the passive oral desires which are used in the learning process because if he learned he would have to be impotent. For him learning meant having the teacher's penis shoved down his throat where it would make a child (fattened like a goose) and then the child (penis) would be eaten. He could only retain his penis and be successful sexually if he repudiated his desire to learn. The solution of the problem for him lay not in his inhibition of the ability to take in as in the former case but in his active repudiation of the ability to learn.

In this patient his sexual life and his penis was retained at the expense of his ability to learn. In other patients the ability to learn is accentuated and the sexual life is given up.

Case 34 A boy of eight was referred because of temper tantrums, fears, and annoying behavior at home. He had a moderately high IQ, but his store of knowledge and ability to use it was far in excess of his intelligence. He knew and could discuss very intelligently all of the famous musicians. However, he was more interested in displaying the fact that he knew their names, the dates of their births and deaths, and the names of their compositions than in discussing their work. In a similar fashion he dealt with astronomy, insects, animals, and plants. He performed rather intricate arithmetical computations in his mind, and the answers were always correct. Again he was more interested in demonstrating how far he could count and the names of the denominations above the billions. It was obvious that his parents were proud of his intellectual accomplishments and encouraged them—and it was equally obvious that they did not perceive the esoteric quality in them. He was not interested in having friends, and of course his curious intellectual accomplishments and the pleasure he received from demonstrating them on all occasions appropriate and inappropriate made other boys and girls of his age dislike him. He was not interested in sports and particularly did not like to draw or paint. He always deprecated his efforts along these lines. With his parents and their friends he tended to behave babyishly in a rather annoying manner.

His behavior resembled that of the patient in Case 25. In the latter patient his store and use of knowledge not pertinent to his vocation, not pertinent to his interests, and not pertinent to the situations where he demonstrated it, was the expression of a fantasy that he was a great, actually big man. His lack of knowledge of his vocation, his reluctance to acquire more, and to use that which he had acquired, represented a fantasy that in reality he was a castrated man. The behavior, therefore, was the result of a disturbed relation with reality, not of reality testing, but of a dependence on fantasy rather than on reality. This phenomenon is universal in all human beings to a greater or less degree. It is found to a degree less than in these patients in two common situations.³ Many people have a firm belief in immortality and the benefits of the hereafter over this present life. Yet in spite of this belief, when they become ill, they call a doctor and insist strongly that he help them get well. Certain people have a fanatical belief that the present social and economic philosophies, as practiced in the Soviet Union, which are not Marxist social and economic philosophy, are greatly superior to those of the rest of the world, but they do not attempt or even dream of going to live in the Soviet Union. Both of these groups depend more on their fantasies as beliefs

³ I am indebted to Dr. Robert Waelder for the following illustrations.

than they do on reality, therefore their relation to reality is disturbed. A greater degree of this disturbance is demonstrated by these two patients. I will refer to a further degree of this disturbance later.

The boy I am discussing at this time showed many reasons for his disturbed relation to reality. In his fantasies he showed that he could not wait till he had taken his father's place but that this urgent desire would result in his castration and destruction. In his stories a family (his) was killed by eating and then the hero explodes because he eats too much. The hero eats all his mother's and father's food and then goes to a hospital where he has his hand cut off. The hero dies after his father but when a person dies he becomes someone else so after the patient dies he will become his father. He desired to be alone in a world where particularly there were no animals and no hears. He would like to have no middle name; his sister does not. (He hated his sister because he wished to be her in order to possess his mother completely.) He told me he had to know my middle name so he could describe me to other people. Then I could be arrested for I was a criminal for loving my wife whom he hated, as he hated his mother for loving his sister. At the same time he wanted me to drive him home after his appointment, and desired to stay with me all day and go home with me so I could not have a chance to see any other patients. These fantasies indicate his extreme confusion of his feelings toward me but also his confusion as to his identity and his sexual orientation. I should be arrested for loving my wife instead of loving him, so he wishes I would hate my wife and love him as he wishes his father would hate his mother and love him instead. I have a middle name so I could be found and arrested, but he has a middle name; therefore he should be arrested for loving his mother, whom he says he hates because she loves his sister; so he should be arrested again for hating his mother. His mother loves his sister, therefore he hates his sister and should be arrested for this. He wants to be his sister in order to be loved, but if he is his sister he will have to hate himself. This confused picture breaks down into the following feelings. He wants to punish me for not loving him as I love my wife as he wants to punish his father for not loving him as he loves his mother. He fears this desire because it will result in castration. He says he hates his mother. This is a repudiation of his love for her in order to repudiate his hatred for his father, but he also hates her because he wants her to love him instead of his sister. He should be punished for this hatred. He hates his sister and he should be punished for this by becoming the hated person.

His sexual fantasies also were frightening. He told me women cough to have babies. They cough their insides into a knob and then cough this knob up and it becomes a baby. Men's insides are stuck together so they cannot cough a baby up. When a woman coughs up a knob and the knob sticks to the mother it has to be cut out and then it becomes a girl.

As a solution to these problems of his extreme confusion of love and hate toward objects he would prefer only to play marbles with me until all of us, including himself, die and then he will not have to discuss these problems with me. The step from playing marbles, which was a counting game, the winner being the one who had the larger numerical score, to the interest in and ex-

cessive ability to compute numbers lay in the magical value he placed on them. He had marked likes and dislikes about numbers as an example he disliked the number 52. He told me that the two represented a baby i.e. his sister and five was the year of his life which he did not like. Among other unpleasant experiences during that year the daughter of a friend of his family who had been ill from birth suddenly died.

His interest in knowledge not related to his age level seemed to be an attempt to avoid reality with which his relation was disturbed because of his very conflicting and very frightening fantasies and to replace his fantasies which became frightening because they terminated in his castration and death by thinking about abstract concepts. It allowed him to attract his parents' attention to him as a *big* boy and away from his *little* sister and to act out his fantasies of killing his father, his mother and his sister and being loved by his father and his mother in a way so disguised that he did not need to dread them. At this time and it was true also in my adult patient the replacement of the emotional conflicts by the interest in esoteric knowledge avoided the fear that would have occurred if they had been replaced by real usable knowledge. Whether later in this boy's life even the storing and use of the impractical knowledge will come under the influence of the fear and so be unusable I do not know. It had not happened in my adult patient.

In the case of this boy the oral elements in the fantasies are plainly evident. The presence of a fixation at the oral level which produces either an excessive need for oral incorporation or an excessive fear of the ability to incorporate orally interferes with the ability to learn and may result in amnesia for what has been learned, an inhibition of the ability to learn, an active repudiation of the ability to learn or an increased ability to learn but to learn only useless information.

These cases are all quite pathological and their illness is so severe that they can be diagnosed and treated with any hope of success only by a specialist in the psychoanalysis of children. They are not influenced by educational techniques nor by psychotherapy.

C Diminished Capacity to Learn Due to Disturbances in the Assimilation and Digestion of Knowledge

Difficulties in learning arise not only in disturbances in the ability to take in knowledge, a disturbance of the mechanism of oral incorporation but may arise from disturbances in the ability to associate, correlate and assimilate the incorporated knowledge, i.e. in the ability to digest it. This is the most serious type of learning difficulty. It may be so severe as to show itself in the results of the psychometric examination.

Case 354 At the age of four this boy had been examined by an extremely competent psychologist who was very experienced with children. He obtained an I.Q. of 50. At the age of twelve after a long period of analysis he had an

4 I have reported this case elsewhere (1940)

I.Q. of 110 and his accomplishments later on showed that his real I.Q. must have been over 140.

I do not know whether serious reading disabilities fall in this group or not. Certain reading disabilities may be due to strephosymbolia or to some of the other causes I have mentioned already but certainly the really severe cases cannot be explained on these bases. Blanchard's (1935, 1936 a and b, 1946 a and b) studies seem to indicate that they are cases of difficulties in digesting and assimilating learned material. In my cases this inability to digest always was associated with a disturbance of the ability to take in and to give out.

Case 36. A ten-year-old boy was referred by a psychologist to whom the patient had been taken for a psychometric examination. The report of his psychometric examination was as follows:⁵

I spent nearly three hours with the child, found him very co-operative and pleasant in manner, but also very distinctly *slow* in reaction and infantile in many of his behavior patterns. I have purposely underlined a word in the preceding sentence in order to emphasize a point which I consider to be of vast importance. It would not be quite appropriate to use descriptive terms such as "dull," or "apathetic," or others, which commonly are used in depicting the reaction patterns of mental deficiency. In other words, in spite of the implications of the quantitative psychometric data presented below, most of the qualitative features of the boy's behavior were not those conventionally found among definitely subnormal children.

The psychometric results were as follows:

Stanford Binet Scale: (1916)

Mental Age: 7-6

I.Q.: 76

Kohs Block Designs Test:

Mental Age: 10-1

I.Q.: 102

Witmer Formboard

Witmer Cylinder

Paterson Formboard

Dearborn Formboard

} Two trials on each

Estimated M.A.: 7-9 to 8-0

Estimated I.Q.: 78 to 81

Detroit Reading Test:

Grade Score (Test I): 2.3

Grade Score (II) : 2.6 (Approximate middle 2nd grade)

⁵ I am indebted to Dr. George Carl for this report.

I can best describe this boy's departure from ordinary reaction patterns, on all of the tests, by explaining what happened on the Kohs test, which was given first. Almost at the beginning he seemed to become confused, and was unable to do one of the very simple exercises. Then he did one, somewhat more difficult, without much trouble—and another immediately following. Again he bogged down badly, and again I felt certain that he had reached his limit of performance. But, as in the former instance, he once more "caught on" and did several more stems with facility. This erratic kind of performance was evidenced in other tests as well. Penalties were severe, particularly on Stanford Binet, as a result I was constantly under the impression that the boy's intellectual appraisal of the various test situations was normally good, but that the strikingly infantile nature of his emotional response kept him from getting across the line which separates failure from success in scoring the test performances. Actually he did not pass a single item in Year IX on Stanford Binet, though I am morally certain that he really understood most of the questions quite well.

I have a strong feeling that the lad has been babied a good bit, and has not been given a good chance to develop as much self resource as he could have. I noticed that, as I prepared to take the boy with me to the examining room, his mother gave him last minute instructions about doing everything I asked him to do, and otherwise evidenced some concern as to how he might act. As you doubtless have found out already, he is very much of a "sissy" in many ways—dislikes vigorous sports, likes to play with younger children. Many of the speech mannerisms are distinctly on the infantile side.

I am by no means certain that his case is not one of conventional subnormality, but, as mentioned above, there are enough departures from the conventional configuration to make me feel that the difficulties may be attributable to delayedness in development and dysfunction rather than to basic lack of intellectual capacity. For one thing, the gross physical and motor organization is of the kind often encountered in cases of subnormal function—in contrast with a condition of subnormal capacity. While, I believe, I tend to bend over backward in regard to imputing any kind of subnormality to endocrine influences I should not be surprised to learn that, in this child's case, some factors of that kind are partly responsible for the condition. And almost certainly there are penalizing influences on the side of the affect patterns.

This is particularly a case in which I cannot have strong convictions without the benefit of more data than those secured in the present limited examination.

Patient was a large, rather obese boy who suffered occasionally from headaches and frequently looked depressed, although he always denied feeling that way. He preferred to play with girls rather than with boys but seemed most contented when in the house with his mother. He was docile and always tried to avoid any change. For months on end he always placed his chair in the exact position in the playroom where it had been the first day he saw me, sat in the

chair and showed no desire to play with any toys. He did play with his cap and with his hands, and from time to time he reported a number of fantasies associated with his play which I will report later. He had a compulsion to wash his hands frequently. He showed mild grimacing movements of his mouth of a very infantile nature.

His father had a marked harelip with a speech defect. He was a successful business man who seemed more interested in his occupation and his hobbies than in his son or in his family. His mother was a rather stolid person who originally had babied the patient. But she seemed to be fonder of the patient's twin sisters, who were born when the patient was seven, than of the patient. When the patient was six, the mother had a second son who lived only one month.

The patient was born with a mild inguinal hernia which corrected itself. He was breast-fed for eight months and then weaned to a cup. At fifteen months he fed himself. There was no finger sucking. He walked at fifteen months and talked at two years; hence his rate of development was not as slow as his I.Q. seemed to indicate. Between one and three, the parents had lived with the paternal grandparents, who babied the patient and preferred to dress him as a girl. At four he had a tonsillectomy and adenoidectomy. In the same year he was pushed by another boy, hit his head on the sidewalk and suffered a mild concussion. It appeared that his headaches, which had the character of migraine, developed some time after he had been bit again by a boy when he was eight.

He entered school at the age of five and completed the first grade successfully. He had to repeat the second grade. During this second year in the second grade he was tutored. At the time of examination he was in the third grade but was failing. The reasons for his failure lay in his apparent inability to learn the school work and in his methods of thinking which are well illustrated in the report of the psychological examination and by the following reports from his teacher who kept notes on his replies to various questions:

Teacher: "In what way are a baseball and an orange alike, and how are they different?"

Patient: "An orange is round and a baseball is square and when you throw 'em they're very soft. What did you say?"

Teacher: "How are they alike and how are they different?"

Patient: "An orange is much different from a football."

Teacher: "A baseball."

Patient: "An orange is round and a baseball isn't."

Teacher: "What would you do if you found on the streets of a city a three-year-old baby that was lost from its parents?"

Patient: "Well, I would take it home to my own home and keep it till she died."

Teacher: "Can you give two reasons why most people would rather have an automobile than a bicycle?"

Patient: "If children's too little to ride in an automobile the car might go down the road and the children might scream for their mothers. You can't have both."

Teacher: "How are a book, and a teacher and a newspaper alike?"

Patient: "A newspaper is some kind of paper you can tear easy and a book is heavy paper like drawing and a teacher is made out of skin"

While making a bead chain, the patient very excitedly commented, "I don't have enough blocks to go around Let me tie the teacher Put a neck lace around her. I'm afraid its going to choke her Better not tie it" [Silly giggle]

Teacher: "What should you do if another boy hits you without meaning to?"

Patient: "The other boy would probably say, 'I'm sorry I won't do it again'"

Teacher: "What should you do?"

Patient: "I don't know What *should* I do?"

Teacher: "What clothing do people need?"

Patient: "Hats, money, shoes, underwear, corsets, stockings"

Teacher: "Can you think of anything else?"

Patient: "Some more clothes Jewelry [repeated many times], hair, sweaters, coats, stockings, valuable things, wool stockings, fur coats, tablecloth"

Teacher: "What food do we need?"

Patient: "Cookies water, towels, water, bathtub, shower, eyes, and nose, mouth, all their body"

Teacher: "Can you think of anything else that people need?"

Patient: "Some people need doctors and have to go to a hospital Some people have broken arms—don't have anything to wear"

Teacher: "What do people need to live in?"

Patient: "House, land, grass, driveway, garage, door, back door, two front doors radiator, porch, pictures living room furniture"

After the teacher and the class had talked about basic needs for several days the patient was asked if he could think about the things that had been discussed and tell what he thought people needed most His list was Money, clothes pants, underwear, stockings Shelter—houses, beds Meat, ice cream, dishes Toilet" [Repeated many times]

Teacher: "Do you know where clothes come from?"

Patient: "Yes, wool Sheep sometimes"

Teacher: "What else do you know about clothes?"

Patient: "Well—sheep, wool—farms My milk comes from the cow My sweater is made of sheep My pants and socks and shoes are made of sheep Hair Other clothes—other little woolen dresses—Mommies dresses Fur coats"

Teacher: "Do they all come from sheep?"

Patient: "No Little Bo-Peep lost her sheep I don't know"

Teacher: "How do you think we can find out?"

Patient: "Ask somebody at a farm Any barn that has sheep or animals They might tell you"

Teacher: "How do you think we could find out if we couldn't go to a farm?"

- Patient "You might go to a stranger and ask them Maybe you wouldn't know their house or they wouldn't have a telephone."
- Teacher 'Where does meat come from?'
- Patient 'The store? It grows in the ground All meat comes from animals. Lamb chops come from goats'
- Teacher 'Can you tell me the names of some vegetables?'
- Patient 'Potatoes mashed potatoes, string beans, lemonade in hot weather, orangeade'
- Teacher "Are you thinking of vegetables?'
- Patient 'Green beans, peas'
- Teacher 'What meats can you think of?'
- Patient 'Hamburger, steak, roast beef, tenderloin, cold water, oranges onions, cabbage, lettuce, tomatoes bread, orange juice, tomato juice, milk, toast, jellies eggs, bacon, cookies, crackers, cheese, beets."

The position in which he kept his chair in the playroom, his refusal to play with toys his preference to play with his hands and his cap his dislike of active play and his preference for staying in the house with his mother had the same basis as his hand washing compulsion i.e., a dislike of getting dirty This was based on his fear of masturbation He told me he was afraid to move out of his chair lest he step on a snake whose blood would gush out. Also the snake might bite his nose and eyebrows If his hands would become dirty, his father would become ill, his mother would go away or a burglar would enter the house and kill his father mother and a boy These masturbation fantasies therefore consisted of a fear of castration if he hated his father, his mother and his dead brother It seemed that he felt responsible for the brother's death Certainly his maternal protective behavior to his twin sisters and his constant and insistent denial of any dislike of them, no matter how much they infringed on his rights, seemed to be a reaction formation against his feared hatred of them.

He persistently refused to use his left hand for any real purpose. He told me that his right hand was a man and his left hand a woman One man disposes another of the woman and the other both are married to her but the men have to live in separate houses

He told me he played mostly with girls because he would like to be the third grade teacher a woman and because he would like to be a girl for girls' clothes were so pretty At the same time he told me that though he was afraid of boys because they fought, he would like to be a boy

He felt he was responsible for an appendectomy which a girl friend of his had suffered several years before by hitting her in the stomach As I mentioned earlier his fantasies seemed to indicate his idea that he caused his brother's death Usually he did not like to mention the dead brother but he often prayed for him, although the family were not Catholic.

The games he played with his hands were as follows

(1) A baby is playing behind a fence It gets out but comes back and its parents feed it. Then it goes to bed gets up and a whirlwind destroys the house, the parents and their baby

(2) My playroom was my apartment but when I am asleep there a tramp comes takes my bed away eats me up in order to become strong

(3) There was a bad boy whose mother kept him in and whose father punished him. Although the boy did not like the punishment the patient felt it was entirely just (On another occasion when I knew he had been punished shortly before he told me he was quite happy about the whole incident) The boy's name was Billy (This was the name of the patient's dead brother and of the family dog who had been sent away because the twin sisters became ill from eating the dog's hair. The patient was fond of the dog but expressed no sorrow when the dog was sent away)

(4) There was a big boy whose mother was killed in a storm. The boy hurt his hand and had to go to a hospital. The mother was killed and the boy and his father lived happily ever after.

(5) A tramp came after me and bored a hole into my room and through me. He also bored a hole through the patient. This game occurred at the time he was telling me that he was fonder of a girl friend of his than he was of his mother.

(6) His hands were a baby and he was the mother singing the baby to sleep.

(7) A father is in the hospital and the mother goes out and leaves the boy. She returns bringing a cake but goes out again. The boy does not touch the cake. The mother, father and boy go to the grandmother's. While they are away a burglar destroys the house and when the family returns the burglar kills them. The mother still lived so the burglar shot her in the stomach.

(8) A father and mother have no children. They go out to dinner. The mother faints on her return because she is going to have a baby. The baby fully dressed is cut out of the mother's leg. The baby is a girl who is very ill and will die.

(9) A father kicks a mother and baby out. The mother kicks out the father and the baby. The mother and baby go off to dinner and leave the father. The mother breaks her back and dies. Everybody dies.

(10) A boy went out to play and fell in the river. He came home was spanked and put to bed without supper. Then he was neglected for the twins. The boy and his mother got mumps and measles and went to the hospital.

This boy had a severe obsessional neurosis which was the result of his attempt to solve his fear of his hatred of his father and of his mother. He feared his hatred because he believed it formerly had resulted in his brother's death and because it would result in his own castration and death. He attempted to solve this problem by attempting to be both a boy and a girl with a preference for being the latter as a masochistic defense against his sadism and by a regression to the anal sadistic stage of development. He found that this regression was no solution and he was forced to erect further defenses of reaction formations of docility, obedience, lack of movement and refusal to make any change, isolation, undoing and by diminishing his capacity to learn. He restricted his intake of knowledge because it meant cannibalistic incorporation, for which he would be killed.

None of these mechanisms, however, explain his confused thinking and the

alternations of knowing at one time and being ignorant at another, excellent examples of which can be seen in the reports of the teacher and the psychologist. The type of thinking shown here is very like that seen in dreams whose bizarreness is the result of the fact that the primary processes of the unconscious are freed temporarily during sleep from the logical secondary processes of the ego and of consciousness. His thinking was controlled by these primary processes and so he often appeared unable to think in the usual logical secondary processes. This made it difficult for him to associate, catalogue, and assimilate any knowledge that he learned.

His regression did not involve only his psychosexual life but it was a real regression in ego functions also. I believe the real distinction between a disorder of learning, due to deflection of attention from the data to be learned to the attempt to solve a serious intrapsychic conflict, and this type of case lies in the fact that, in the former, the secondary processes of ego activity remain in command, while, in the latter, the regression causes the primary processes of psychic activity to predominate. Their effect is to disorder the ability to catalogue, associate, and make logical the knowledge which is learned. In these cases the real problem is the accentuation of the primary processes due to regression. They basically are severe obsessional neuroses.

The severe regression from the secondary processes of thinking to the predominance of the primary processes forms an important difference between this group of cases and another group of cases of learning disorders, to which I have alluded already, cases which show a disorder of the relation to reality.

VI DIMINISHED CAPACITY TO LEARN BECAUSE OF A DISTURBANCE IN THE RELATION TO REALITY

Case 37 A college student was referred because he showed a beginning paranoid schizophrenia. He had a very high IQ although his scholastic achievement in high school was mediocre and he flunked his freshman year in one college and his work in a second was just better than failing. His family thought that this was due to his indulgence in too much social life and admonished him from time to time to do more studying. When the apparent full social life of this patient was studied carefully it was found that it was an expression of a fantasy of megalomania. Really he felt quite inadequate in social relationships in his own social, economic, and intellectual level. With these people he felt very inferior. His apparent full social life was spent in a small rural community. Here because he was a college student and the scion of a wealthy family he was a big frog in a small puddle. He served as the advisor for the town's people and actually helped many who were in difficulties. This was very gratifying to him because it overcame his feeling of inferiority. He did not seem to realize that he could be of greater help if he achieved graduation from college and from a

professional school. He failed in school because he was unable to perceive that his fantasy was not realistic.

This patient's other symptoms indicated that he suffered from paranoid schizophrenia, perhaps actually from a true paranoia. I have seen a number of other patients whose failure to learn seemed to be the result of disordered ability to digest and assimilate their ingested knowledge but who gradually developed the characteristic clinical picture of schizophrenia. It is a matter of common knowledge that the intellectual ability of certain very brilliant adolescents seems to burn out by the time they reach adulthood. At this time they begin to show more or less marked signs of schizophrenia, often of the ambulant type. Their intellectual ability is very mediocre, and this decrease in intellectual ability seems to retard the progression of the schizophrenic process.

I would suggest that failures in learning as the result of disorders of assimilation and digestion fall in two diagnostic groups:

- (1) Severe obsessional neurosis where the regression is so deep as to reinstate the supremacy of the primary processes
- (2) Moderately severe cases of schizophrenia where the failure in learning is due to a disturbed relation with reality

The diagnosis and treatment of both of these types of cases is the prerogative of the psychoanalyst. Cases of severe obsessional neurosis require psychoanalytic therapy. Even in the hands of a skilled psychoanalyst of children the prognosis of the learning difficulty is poor. Often the other symptoms of the obsessional neuroses can be removed but the disorder of thinking and particularly the IQ level may not be much improved. The cases of schizophrenia which show failures in learning require treatment for the schizophrenic process.

VII DIMINISHED CAPACITY TO LEARN BECAUSE THE CHILD HAS NEVER LEARNED TO TOLERATE THE ANXIETY PRODUCED BY THE LACK OF GRATIFICATION OF INSTINCTUAL DRIVES

Educators and particularly progressive educators, in the last few years have become aware of a peculiar phenomenon in certain children. On entering school these children seem to lack any interest in learning. Instead of being interested in acquiring knowledge they are interested only in the immediate gratification of their desires. Learning to read is boring because it requires effort and interferes with their immediate pleasure. No matter how hard the teacher tries to arouse their interest and hold them to this task by making it pleasurable, the results are slight or nil. In fact, these children will state openly that they do not

intend to learn nor can the teacher make them. These statements do not sound defiant or stubborn but simply matter of fact.

More peculiar still is the fact that such children come from homes which appear to be the best. The parents are interested in the acquirement of knowledge but do not force their children to follow in their footsteps. They interfere as little as possible with the manifestations of the various stages of psychosexual development. Toilet training is done easily and slowly, there is no interference with finger sucking, masturbation, curiosity or exhibitionism—in short, it seems as if they gave their children every opportunity for successful development. But when the upbringing of these children is studied carefully, two misconceptions are found. The child has been permitted to operate always on the pleasure pain principle. He has been protected as much as is humanly possible from any pain or any interference with the immediate gratification of his desires. The parents are not only extremely permissive toward his gratifications but actually almost turn themselves inside out to see that he is gratified. They do not wish him to experience any pain or anxiety. These children therefore have not learned to tolerate any anxiety, particularly that which arises when the immediate gratification of an instinctual desire is prevented by reality. As Fliess (1952) states, this is one of the typical and most frequent misapplications of Freud's findings. It reverses the whole parent child relationship for here the adult identifies himself with the aggressor, who in this case is the child instead of vice versa.

As a consequence the development of the ego defenses of repression, reaction formation, change of aim, and sublimation, i.e., the development of the organization of the ego, is greatly retarded. Sexual curiosity is not changed into curiosity about the nonsexual aspect of the world but remains sexual curiosity which is gratified constantly. Such children have no energy to learn at their disposal and their desire to learn cannot be stimulated even by making the subject to be learned as interesting as possible. They only will begin to learn when they are subjected to the slow educational process of being compelled to postpone immediate gratification of instinctual drives and to begin to tolerate the anxiety which necessarily must arise during this educational procedure.

Such children require the kindly but firm management of a teacher who understands the importance of helping the child subordinate the pleasure pain principle to the reality principle. The psychoanalyst can make the diagnosis and as a consultant can help the teacher, but the main part of the therapy lies in the hands of the latter.

CONCLUSIONS

A diminished capacity to learn is a frequent symptom shown by children at the present time. The ability to learn is a function of the ego and therefore its disorder is produced by influences which affect the ego functions.

A diminished capacity to learn may result from

- (a) organic defects and the effect of physical defects and illnesses
- (b) improper and unpleasant conditioning experiences during the process of learning
- (c) current disturbances in object relationships
- (d) emotional reactions such as apprehension of dangers to the child's security, feelings of shame, guilt and embarrassment, feelings of horror and fear, engrossment in instinctual desires and the focusing of attention on daydreams. These produce a deflection of attention from the subject to be learned.

These four groups of causes are well known to educators at the present time. In these types the capacity to learn is diminished indirectly.

- (e) the learning process itself has become involved in the neurotic conflict. In these cases the diminished capacity to learn may result from an inhibition of the use of learning from disturbances in the ability to ingest the data to be learned or from disturbances in the ability to digest and assimilate the learned material.

In these cases the capacity to learn is diminished directly by its involvement in the neurotic conflict.

- (f) disturbances in the relation to reality
- (g) the fact that the child has not learned to replace the pleasure principle by the reality principle and so has never been compelled by reality to tolerate anxiety.

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NOTES ON CHILD REARING IN AMERICA

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Why have the principles—or rather the catch words—of psychoanalysis been taken over so eagerly and misused so consistently among certain circles in America? What, of all that psychoanalysis has to offer, has been taken up by some parents and some educators in America?

Chiefly, and in the first place, it has been the idea of infantile sexuality and the implications of this idea for child rearing. It is well known what is meant by this, and the point hardly requires extensive development here. Freud's work has shown us that early sexual prohibitions lead to severe neuroses. For parents and educators the practical implications have been to influence the timing and the mode of toilet training to allow more dirt and water play in the early years, to teach that the child's early sexual curiosity should be treated naturally, without lies, and that the child's sexual behavior should not be treated in such a way as to overstress shamefulness at the phallic phase. In short, Freud's contribution to our understanding of infantile sexuality has been practically used to avoid inhibiting the child's primitive drives. I oversimplify the terminology here because of the relation of this consequence to what I shall say in general about the popularization of psychoanalytic principles in America.

Another idea of psychoanalysis that has been so readily accepted in America has been the understanding that suppressed aggressiveness may also lead to severe neuroses. Now the essence of this idea was not new in America. Throughout American history, Americans have from time to time recognized the irrepressible quality of aggression in the human personality. But the psychoanalytic influence has surely revived and stimulated the feeling that children's aggressiveness cannot be dealt with merely by suppression. We may say of this that, on the one hand, the tolerance of aggression stems partly from the adult's insecurity in dealing with the child and that, on the other hand, the overdevelopment of the aggressive component of the child's personality increases the adult's insecurity in dealing with the child.

Again, in this second principle, the adapters of psychoanalytic concepts have stressed the permissive aspect of those concepts.

In the third place, psychoanalysis has revived popular awareness of the significance of the home in the personality development of the child. Now, I wish to point out that here again we have only a revival, not something new in America. In the period 1830 to 1860 in New England, there was a great flood of parents' manuals, most of which expounded the thesis that not only the child's personality, but the whole future of America, depended upon parental and, in particular, upon maternal guidance, behavior, and personality.

"Is not the character of the future men of our republic, to depend on the mothers we are now educating?" wrote one pamphleteer in 1839 (quoted from Anne L. Kuhn, 1947). There was nevertheless a reaction in the early twentieth century toward the emancipation of women from the home, a depreciation of the role of motherhood, and a reduced understanding of the importance of the home and the mother in the development of the child. This reaction has been partly arrested in recent years by the influence of psychoanalytic principles.

The major influence of psychoanalysis, both in the schools and in the home, has been in the direction of preventing the child's inhibitions, allowing free play to his primary processes. Interestingly enough, other basic concepts of psychoanalysis, such as identification, sublimation, reaction formation and so on, have been almost completely ignored. I have often found in teaching psychoanalytic principles to educators that I have much more difficulty in making my students understand these principles than in conveying the subtleties relating to infantile sexuality and childhood aggressions.

My question posed at the beginning of this paper thus acquires a subquestion. We must ask not only why psychoanalytic principles have been accepted so readily in America but why the permissive aspect of psychoanalytic implications is the one that has overshadowed all other aspects. And if we answer this then we may better understand the misuse of psychoanalytic principles by parents and educators.

The answer lies, I believe, at least partly in the whole tradition of child rearing in America—or rather in the lack of tradition that has for centuries allowed a permissiveness toward and an indulgence of children by adults that far surpasses anything we have ever known in Europe.

As long ago as the early nineteenth century, European travelers in America remarked, some with great pleasure and others with extreme disapproval, the free and independent attitude of American children.

Among those who disapproved most, as she disapproved of almost everything she saw in America, was Frances Trollope, mother of the novelist Anthony. She wrote in 1832, of the "rude indifference, which is so remarkably prevalent in the manners of American children."

"I have conversed," she said, "with many American ladies on the total want of discipline and subject which I observed universally among children of all ages, and I never found any who did not both acknowledge and deplore the truth of the remark"

David Macrae, a Scotsman who visited America in the 1870's, supplied instance after instance of the precocity and independence of American children, concluding "One can understand what a New England lady meant when she said, 'I am learning to be a docile parent!' 'Parents, obey your children in all things,' is the new commandment We may next, as somebody suggests, see on the signboard of some American store, instead of John Smith and Son, 'J Smith and Father'" This in 1870!

In what way can we account for this strain of permissiveness through the centuries in the attitudes of American parents to their children? I think part of the answer is to be found in the lack of a firmly structured tradition of child rearing such as was known in Europe. The population was too diverse, too mobile, too oriented to the future to allow the gradual accretion of a national or even regional or local traditions. In the absence of such traditions the adult's normal insecurity with the child was left unsupported, and an inclination toward extreme permissiveness was the consequence.

But more than this is required to account for this phenomenon of permissiveness. We must consider the real need in America that the child be independent and that he grow up to be an independent man as soon as possible. Even in the early Puritan settlement where the severe discipline extended to adults and children alike, it was a fact that the children were far more precocious than their parents had been in England before them. The conditions of life required this. The children had very early to take on adult responsibilities or the colony could not survive. And this was true later in the settlements of the West. Precocity and independence were required by the objective physical circumstances of the life.¹

In addition, they were required by the objective economic and ideological circumstances of the life. Expansion and progress were part of the American culture. To be a success à la Horatio Alger required the earliest possible breaking away from the influence of the home. The son should not be like the father, but more and greater and better and—if the father was an immigrant—more American. "In fact," says Erikson (1950), "the psychoanalysis of the children of immigrants clearly reveals to what extent they, as the first real Americans in their family, became their parents' cultural parents." But even in nonimmigrant families, the

¹ Cf. Calhoun (1945)

son took his ideals from the community and not from the home. His object of identification was not supposed to be his father, but the Abraham Lincoln of the day. This was tacitly accepted by both father and son.

The respect for the child in America has been not a respect for the child as child, but a respect for the man in the child, for the future citizen, money-maker, politician. This attitude carries over into our own day and is well symbolized by a song taught by adults to children in many schools and camps: the children ask their parents to forgive them the many sins of childhood for, "We're the younger generation and the future of the nation."

In a way American parents have equated independence with permissiveness. And since America has been a country where adults and children alike have had to be independent, it is a country where the children have also been allowed and indulged. In our day one might almost say that the permissiveness has survived the independence.

I should like to make one further observation regarding the process of the spreading of psychoanalytic ideas. America is a very literate country, and, in the absence of an ingrown, unspoken tradition of child rearing, any minister, school teacher, or reformer who chose to write advice to parents has always been assured of some hearing. And this is particularly true of authors who, on the one hand, elevate the role and importance of the mother and, on the other, require the superhuman of her and berate her for her inadequacy.

"The rule then," wrote Lydia Maria Child in 1844, "for developing good affections in a child is, that he never be allowed to see or feel the influence of bad passions, even in the most trifling things; and in order to effect this, you must drive evil passions out of your own hearts . . .

"It is not possible to indulge anger, or any other wrong feeling, and conceal it entirely. If not expressed in words, a child *feels* the baneful influence. Evil enters into his soul, and the imperceptible atmosphere he breathes enters into his lungs; and the beautiful little image of God is removed farther and farther from his home in heaven."

Poor mother! But was she any worse off than today's mother who is also provided such strict prohibitions and threatened with such dire consequences? Our present-day educators of parents also fail to encourage the mother to employ her intuition in her relationship with her child. Asking her to allow and to stimulate the instinctual life of the child, they make little provision for her own instinctual life with her child.

This is the kind of soil, then, in which the seed of psychoanalytic principles has been sown. Is it any wonder that the results have been what we know them to be?

The sociological reasons for the misuse of psychoanalytic principles

in education surely need not lead us to abandon these principles. It seems to me that there is today some tendency to turn away from progressive education in general. And I feel quite strongly the necessity to defend progressive education and the principles of psychoanalysis in education. We should not turn away from but rather try to correct the misunderstandings that have developed.²

We know from our adult patients the degree to which the school can be a steady focus in the child's life from nursery years through high school, and especially so in the case of disrupted homes. And it makes a difference, after all, if the child likes his school or dislikes it—as so many children of traditional schools in all parts of the country do. Surely the school can never replace the home, but well trained teachers can help parents by providing a personal, rather than a stereotyped and inflexible, application of psychoanalytic principles to the education of the individual child. And they can help the child, through the group, in his social development, individually in the proper development of the process of sublimation, and both socially and individually in his libidinal development.

It must be said further that psychoanalysis has played a significant role in re-establishing the importance of motherhood and the position of the mother among certain middle class intellectual circles.

As to the admitted extravagances committed in the name of psychoanalytic principles, psychoanalysts have an important part to play. This may be done, among other means, by operating more actively directly in the progressive schools. We should try to overcome the tendency to concentrate too exclusively on individual children's problems, remembering that even a psychoanalytically oriented school is still a school and not a clinic. We should seek to avoid those school situations now all too prevalent, in which children are encouraged to give unlimited expression to their primitive drives without providing the educational direction whereby such expression is helped to become sublimation. We may try to influence the direction of the group situation, the attitudes of parents, and the course of the curriculum. The psychoanalyst can advise the curriculum planner on the concentration spans and sublimation requirements of the various age groups. In the matter of curriculum we may profit by re-examining the educational philosophy of John Dewey. This type of psychoanalytic direction of educational matters may be given through staff meetings and seminar discussions of general educational problems.

And lastly, we may remember that psychoanalysis can still operate in

² Cf. Kris (1948) on the relation of psychoanalysis and education

the old fashioned way of analysis, wherever possible, of the individual teacher, who is, after all, the crux of the school situation.

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EARLY CHILD DEVELOPMENT IN RELATION TO DEGREE OF FLEXIBILITY OF MATERNAL ATTITUDE¹

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GENERAL INTRODUCTION

The three cases presented here have been selected to illustrate the relationship between a mother's child care practices and the child's early development, contrasting three types of maternal attitude—overpermissive, moderate and rigid. Aside from this difference in degree of maternal flexibility, the cases have been chosen for their similarities, in the belief that contrasts in the children's behavior and the parent child relationships would thus be more apparent. The three sets of parents are alike in the following respects: they are white, of early American descent, and Protestant. They are between twenty five and thirty years of age. They are college graduates, and the fathers are graduate students and army veterans. They live under comparable conditions on limited incomes drawn principally from government assistance. The mothers are primiparas who had requested rooming in and wanted to nurse. The infants are female, born within a few months of each other. At birth, they all weighed slightly over 7 pounds and were 20 inches long. They developed at an above average rate in both height and weight. At three years, when data collection terminated, they were all sturdy, well-developed children.

The fact that the three mothers were in rooming in is incidental to the parent child relationship study. The Rooming In Project provided opportunity for closer contact with the mothers prenatally as well as for

¹ From the Yale Rooming In Research Project. Department of Pediatrics supported by grants in aid from 1) Mead Johnson and Company 2) The George Davis Blvin Foundation Inc. 3) The Field Foundation Inc. and 4) National Institute of Mental Health of the National Institutes of Health, Public Health Service.

These three case studies are an abbreviation of materials which were prepared under a grant from the National Institute of Mental Health, United States Public Health Service to the Society for Applied Anthropology in connection with the World Federation for Mental Health Seminar on Mental Health and Infant Development.

more detailed observation in the hospital than would otherwise be possible.²

CASE STUDY OF AVIS ARTHUR

I. Prenatal Data

Both Mr. and Mrs. Arthur wanted several children, but they wanted to wait a year or two after marriage before starting the family. Meanwhile, Mr. Arthur entered the army, and his long absence on military duty prolonged the wait to six years. While he was away, Mrs. Arthur worked. At the time of her husband's return, she held a part time literary position, and continued with this until the last month of pregnancy. Since she could carry on this work at home, she hoped to resume it a few weeks after the baby's birth.

Mrs. Arthur applied for rooming in during her fourth month of pregnancy. She stated the following reasons for wanting it: (1) It seemed unnatural to her to have a baby inside of you for nine months, then to have it whisked away after birth, not to learn how to take care of it, and then go home with it with real fear. (2) One of her sisters had a postpartum depression, she herself did not feel very stable, and wanted to get started right with her child. (3) She had heard from respected authorities in child education that mother and baby will be happier to start off together. (4) Her husband also was very much interested. Mrs. Arthur's subsequent expressions of enthusiasm for the rooming in plan included a crusading spirit, a wish to win out against established status quo. "The more I think about it and hear the opposition of people who try to dissuade me, the more I am for it."

Mrs. Arthur hoped she could nurse, it sounded "right and normal" to her. Furthermore, she had read that the breast fed baby is apt to be calm and more affectionate. Her husband also approved of breast feeding as the natural and more convenient way. Mrs. Arthur thus found herself in agreement with her mother who had been able to nurse all her children except the first (Mrs. Arthur), but in disagreement with her mother in law who was definitely against breast feeding, as well as rooming in and natural childbirth. Both Mr. and Mrs. Arthur regarded their mothers as domineering and interfering and they planned against having either of them visit at the time of the baby's birth.

Mrs. Arthur expressed herself as being "delighted, happy, and excited" about the pregnancy. She did, however, have recurrent moments of misgiving about bringing someone else into this kind of world, and once woke up in a cold panic soon after knowing she was pregnant. Occasionally, she worried about the possibility of postpartal depression.

Physically, Mrs. Arthur felt "fine" and "wonderful" throughout pregnancy. However, she had a fanguing and unpleasant month late in pregnancy when she and her husband visited her mother, who criticized everything she did. After Mrs. Arthur came home and was her "own boss," she felt "wonderful and like

² The methodology for data collection in this Project has been described previously in *This Annual*, Vol. V., 1950, pp. 236-274.

a whole person again" She found the fetal movements "fascinating", although they were very active, they did not bother her at all. She looked forward to labor and delivery as something interesting. Her mother, who had insisted on having her babies at home, described the process of labor, including the pain, as interesting and something she had not wanted to miss. She had had a whiff of anesthetic with the first one (Mrs. Arthur) but none with the others.

Neither Mrs. Arthur nor her husband cared whether the baby turned out to be a boy or a girl, and they chose names for both early in pregnancy. In the last trimester Mrs. Arthur found herself calling the baby "he" several times. She explained that although she did not really care whether she had a son or daughter first, she thought it was easier for a girl to have an older brother. Mr. Arthur is an only child. Mrs. Arthur is the oldest of four girls. Her mother had told her that she was disappointed that her first child was not a boy.

Mrs. Arthur described her husband as a considerate, neat and orderly person. They seemed to enjoy a happy and congenial relationship. She was somewhat surprised to find that her pregnancy drew them even closer together and that he shared her interest in natural childbirth, rooming in and breast feeding.

The prenatal data reveals Mrs. Arthur as an attractive, highly educated, conscientious person, with predominantly intellectual and literary interests and a major emotional problem in an uncomfortable relationship with her mother. She was quite introspective about her family relationships and discussed them freely in relation to her plans for bringing up her child. She had read that a woman could not be a good mother unless she had straightened out her relations with her own mother. Her relations with her mother were far from good. She had always thought of her as a terribly difficult person, hypercritical, inconsistent and unstable, with unaccountable alternation between smothering love and sudden rejection. In spite of their present wide geographical separation from each other, she felt her mother "as a threat." Mrs. Arthur and her sisters had always felt very close to each other, because they shared this common problem of their difficult mother and their dislike of the disciplinary nursemaids engaged by their mother to control their behavior.

Mrs. Arthur remembered both parents as strict and very modest, avoiding mention of the genital region. When nine years old, she heard from schoolmates that babies were born from inside their mothers. It took her months to get up courage to ask her mother about this, but when she finally did, her mother was nice about it, and told her the truth about the woman's part.

During childhood while she was more tied up with her mother, she was rather scared of her father and aloof from him. With onset of adolescence she found him very congenial, and she began to be interested in the type of activity he approved. He always said his daughters would go to college and fit themselves to earn their own living, whereas their mother always said they would "come out" and make rich marriages. She described her father as patient, kind and judicious, never losing his temper; also stubborn and prejudiced and baffled by his personal relationships.

Because of Mrs. Arthur's unhappy memories of her upbringing, she was

determined to rear her children differently "in practically every way." She found strong support in the current literature for her emotionally determined interest in permissiveness in infant care practices. She accordingly took her stand definitely in favor of the so-called "ad-lib" methodology. She would, however, try to avoid spoiling her child by inconsistency and overprotection, and stated that "a mother owes it to herself to keep up other interests and not to become a slave to the child."

II. Labor, Delivery, Hospital and Neonatal Data

Mrs. Arthur was at home in bed when the membranes ruptured at midnight. Contractions began a few minutes later, and she was brought to the hospital by her husband. He stayed with her until she went to the delivery room. Patient was given demerol four hours after labor began, before the contractions had become uncomfortable. A little later she complained of her head swimming, and said that she didn't want more "dope," that she would rather feel in command of the situation, even though there was some pain. But several hours later when the contractions became uncomfortable, she took three seconal pills at half-hour intervals without objection. She was taken to the delivery room just half an hour before the baby's birth, was given whiffs of anesthetic with contractions, and finally anesthetized with nitrous oxide and cyclopropane 20 minutes before delivery. Nine and one-half hours after labor started, a baby girl was born spontaneously by breech presentation with routine episiotomy. The placenta was expelled nine minutes after the baby's birth, and Mrs. Arthur became conscious a few minutes later and expressed delight with her baby girl, to be named Avis. The baby cried well with stimulation, and appeared normal. She was placed in the nursery, since there was no available bed in rooming-in.

The possibility of a completely smooth and happy hospital course for Mrs. Arthur was interfered with when it became necessary to tell her two days after the baby's birth that there would be no available bed in the rooming-in unit until her sixth postpartal day. This was a bitter disappointment to her. She cried and developed a headache. On succeeding days, she tried to be philosophical about it, and succeeded in maintaining a cheerful mien. Except for this disappointment, Mrs. Arthur's eight hospital days were relatively easy and medically unremarkable. Her milk came in on the third postpartal day with mild discomfort. On the sixth day she was transferred to the rooming-in unit, where she appeared happy with the baby beside her and eager to learn how to take care of her.

Avis was put to breast 12 hours after birth. Thereafter, during the six days she was in the nursery, she was taken out to nurse at alternate breasts. The baby was often sleepy at the scheduled feeding hour and was then given supplementary formula later in the nursery. The baby took hold of the mother's nipples well on the first postpartum day, and after initial fussing at the breast nursed well. On subsequent days she was reported to nurse poorly, to lose hold of the nipple, and to act starved. On the sixth day in rooming-in, the baby was put on

an ad lib schedule and nursed from both breasts at every feeding. She appeared satisfied during her short stay in rooming in.

After Mrs. Arthur returned home she continued to be interested in the rooming in study. Although she had her own pediatrician she welcomed occasional visits from rooming in staff members and she phoned them sometimes to discuss psychological questions. She felt she knew well enough what she wanted not to be confused by differing professional opinions.

Mrs. Arthur had engaged a practical nurse for the first four weeks after coming home from the hospital. The arrangement appeared ideal since the nurse did most of the housework and took the baby with her in an upstairs bedroom for the night to allow the parents as much undisturbed sleep as possible. However, incompatibility developed between the nurse and Mrs. Arthur during the first week and she was let go at the end of ten days.

Mrs. Arthur followed faithfully her obstetrician's explicit recommendations for rest and very gradual return to her household activities. She was in good physical condition and allegedly was at ease with the baby. Nevertheless she felt exhausted most of the time. In addition to the emotional upset with the nurse the feeding of the baby presented itself as a plausible explanation for her fatigue.

The neonatal period is the only time when feeding dominated the mother-child relationship. The mother responded to the baby's whimpers without waiting for her to cry. Feeding intervals varied from two to eight hours. Fortunately the long intervals came at night. The baby nursed 20 minutes at each breast and then after a short while took several ounces of formula. Each feeding occupied about two hours and Mrs. Arthur felt worn out by the continuous process. By the end of four weeks her pediatrician suggested that she had given breast feeding a good try and would do well to give it up. She did so a week later and was surprised to find how relieved she felt. Avis was obviously contented on formula and continued to thrive.

Mr. Arthur surprised his wife by his immediate interest in watching the baby and his pleasure in holding and feeding her because of his previously expressed opinion that the mechanics of baby care was the woman's function.

III Developmental Data

General Health and Development. Avis enjoyed excellent health throughout her first three years, grew rapidly and had consistently good general development. She was never sick enough for the pediatrician to make a home visit.

She sat unsupported at 6 months, crept at 9 months, pulled herself to standing position at 9½ months, climbed up stairs at 10 months, began to feed self at 11 months, said five words at 12 months, walked unsupported at 12½ months, started combining words and using pronouns at 18 months. At 2 years she made complete sentences, fed herself completely and recited nursery rhymes. At 3 years she could undress completely and put on socks and buckle shoes.

At the annual psychological evaluations Avis showed consistent development at a high average rate. Mrs. Arthur appeared not to put much stock in the tests.

and made it clear that she considered Avis was more advanced than the test results indicated

Personal-Social Development Throughout the first three years, Mrs Arthur tried to make everything she did with her child into a game. From early infancy on, Avis seemed to depend on her mother's presence and claimed her undivided attention. She usually played wherever her mother was, and would not stay by herself for more than 20 to 30 minutes either indoors or outside in the fenced in yard.

Her favorite of her many toys was a little rag doll, given to her in early infancy. She remained continuously attached to this, and at the end of her third year was still taking it to bed with her. Otherwise during the first two years, kitchen utensils were her favorite playthings. These were superseded by dolls, books and clay during her third year.

Mr Arthur spent three or four hours a week playing with Avis, usually in the evening. After the first year he read to her as part of the bedtime routine. Mrs Arthur also enjoyed reading to Avis at every possible opportunity. Since both parents were avid readers it seems probable that they wanted to cultivate a similar interest in their child. Throughout Mrs Arthur's reports she emphasized the child's special interest in books. Toward the end of the third year, she was taking Avis to the public library every two weeks to help in the selection of children's books for home reading.

According to Mrs. Arthur, Avis was always frightened by sudden or loud noises like the shower and vacuum cleaner. In the third year she became afraid of the dark and needed a light in her room, but according to the mother's reports she never had night terrors.

Avis had plenty of opportunity for social contacts outside the home since many children lived on the same block. She liked to watch older children from a distance and enjoyed playing with her contemporaries as long as they wanted to do the same things. There were frequent fights over toys and Avis sometimes pulled hair or pushed without provocation. On the whole, according to the mother's reports, Avis seemed to enjoy company and was always asking to go to other people's houses.

Mrs Arthur's comments give a more friendly and sociable impression of Avis than those of other observers. But even she did not use the word 'happy' in describing her child. Her characterization of Avis at the end of the first year is reflected in her subsequent comments at the end of the second and third years: 'very sensitive, very dependent, extremely sociable, very independent about trying things, exploring, etc. Definitely has a mind of her own, is not suggestible. Very short span of attention. Friendly and responsive.'

Throughout the record by rooming-in staff observers, Avis was consistently described as a large, heavy-set, stolid child with a round, flat, rather expressionless face in contrast to her mother's slender build and mobile, sharp-cut features.

At the one year evaluation Avis did not appear happy. However, after moderate delay she made friendly advances. She was very active and had a short attention span and was not interested in test materials. She appeared least

restless away from the test situation. At the time of the two-year evaluation she was again characterized as very active and restless and having a short attention span. Her response in an unstructured situation was generally friendly but during the test she became rough and unresponsive and outspoken in her refusal of items which did not immediately interest her. At the three-year evaluation Avis presented the picture of a pouting, discontented, unpleasant and aggressive child resorting to tantrums at slight provocation. Mrs. Arthur seemed to have no feeling that her child should be expected to conform to some demands during the test, but she offered Avis much more assistance than was warranted and gave her long, detailed explanations in anticipation of situations which might not necessarily have arisen.

At two and a half years of age Avis entered nursery school. The teachers commented on the child's relative absence of sociability and spontaneous expression. Avis was in general independent, impersonal and undemonstrative with only superficial awareness of the children and adults around her. However, she nearly always remained near some adult whom she could use as an object to facilitate her activities and games. She tended to treat children as objects too. When a child was in her way on the slide, she demanded of the teacher to get this off. When she did develop a relationship with other children, it was usually a teasing one with younger and submissive children. She showed little ability to solve problems or deal with situations other than by walking away from them or demanding immediate adult help. Characteristically, she just kept moving from one thing to another.

Feeding. After Avis was weaned at six weeks, the feeding history is characterized by lack of any obvious complication. Mrs. Arthur stated, *Ad lib* is painless as far as feeding is concerned. Mealtimes were always flexible. Avis always had a good appetite for milk and accepted the various foods offered one after another without difficulty. Mrs. Arthur never tried to force anything. The child's appetite for solids seemed small to Mrs. Arthur, but since she liked a large variety of foods and continued to grow well, there was no reason for worry. Avis was allowed to eat her foods in any order she chose. Mrs. Arthur found by experience that if the child ate her dessert first, she usually went back to her soup and meat. Mrs. Arthur was not perturbed about her child's reluctance to give up the bottle in spite of her pediatrician's suggestions, starting at six months that Avis could begin to take milk from a cup. At two years Avis began to take milk from a glass at mealtimes, but she still had a bedtime and naptime bottle at three years. The important item for Mrs. Arthur was that Avis took more milk from a bottle than from a cup. Moreover, the bottle feeding seemed to soothe Avis and release her into sleep.

Mrs. Arthur was prepared for the general messiness of the one to two-year-old and was able to handle spilling without excitement. However, she was not prepared for the child's deliberately picking up a glass or cup and spilling the contents on the floor. She tried many ways to stop this, including slapping the hand. This did no good and made Mrs. Arthur feel "horrible" so she stopped showing her indignation and "just got the mop." By the end of the third year

Avis ate all her meals in the dining room with her parents. She had good manners, 'acquired by herself,' and although she ate frequently with her fingers, she was neat about it.

Elimination and Toilet Training There was never any problem with either constipation or diarrhea. Avis was given prune juice or prunes every day since she was one week old as a matter of principle, and 'this seemed to work perfectly.'

When Avis was six months old the pediatrician suggested that Mrs. Arthur try to catch the stools. Periodically thereafter, he suggested that toilet training be begun. Mrs. Arthur ignored these suggestions, except for occasional unsuccessful attempts to get Avis to use the pottie during her second year. The failure was not because Avis was afraid of the pottie or toilet bowl. She seemed to prefer to have her stools by herself, so Mrs. Arthur preferred to wait until she wanted to use the toilet. This happened 'overnight' when Avis was almost three years old just after the family moved for the summer.

Psychosexual Development With her mother's willing support, Avis enjoyed nap- and bedtime bottles until she was over three years old. She never sucked her thumb or bit her fingernails. Mrs. Arthur obviously wanted Avis to get oral satisfaction in connection with feeding. She implied that the absence of thumb sucking in her child justified her lenience in regard to bottle feedings. There was very occasional head bumping during the first year, but no bed rocking. Mrs. Arthur did not discourage her child's play in the toilet bowl between 12 and 15 months or her subsequent interest in her bowel movements. Around two years, Avis wanted to see her own stool in the toilet bowl and say good bye as it flushed away, and she sometimes 'took a poke at it.' Mrs. Arthur had expected even greater interest. Genital play was observed by the mother toward the end of the first year during bath time or when Avis had her bottle. Mrs. Arthur had expected this and did nothing to prevent it. She noted its absence at two and three years. The record has no further data on autoerotic activities.

Sleep Mrs. Arthur bemoaned the fact that from the beginning Avis never slept more than two hours during the day. Otherwise there was no mention of sleeping difficulty during the first seven and a half months of Avis' life. By five months she was sleeping through from 6:00 P. M. to 6:00 A. M. At seven and a half months Avis started to wake several times at night and she resisted going to sleep even for naps unless rocked. Mrs. Arthur specifically dated the onset of this problem to the first night of a visit to the maternal grandparents' home, the first visit since the baby's birth. Avis cried all night long the first night and woke up crying on succeeding nights. Mrs. Arthur thought this might be due to the strange surroundings, people and crib. The waking continued when the family was home again, but Avis was more easily quieted. On a second visit three months later, Avis became very upset again and it was worse than ever when they returned home. The Arthurs simply couldn't understand what happened to upset Avis, and they determined that in the event of another child, they would never undertake such visits.

The wakefulness at night continued well into the second year, and brought

the mother to a depressed state of mind in which she felt that her whole life was falling to pieces and that she could never face having another child. Mr. Arthur had no more success than his wife in getting Avis back to sleep. He and Mrs. Arthur took to sleeping in separate rooms so he could get a full night's sleep. They couldn't go out together because Mrs. Arthur was fatigued and usually went to bed right after supper. They couldn't invite people in because Avis would wake up and disrupt the gathering. Mrs. Arthur gave up practically all of her usual outside activities. At 17 months the child began to sleep through the night and there was a three month period of blissful relief. The abrupt end of this good interval coincided with Mr. Arthur's departure for a visit to his mother. Thereafter Avis woke at least once a night and would not go back to sleep in her own bed. Mrs. Arthur thought the child just seemed lonely. She herself hated sleeping alone so she always decided to take Avis into bed with her. She never punished the child in this situation and she was quite unable to let her cry it out as her pediatrician and Spock's book recommended. She couldn't stand hearing the child cry for more than five minutes.

A few weeks before the end of the third year the family moved for the summer. For the first week in the new house Avis slept through the night. The parents naturally hoped that the old pattern of waking was broken but it was re-established when Avis developed a three day febrile illness. So the third year ended with the Arthurs still perplexed and bothered by the sleep problem.

IV Interpersonal Data

Parental Discouragement. Mrs. Arthur's prenatal reactions of happiness, confidence and good health were transformed soon after Avis was born into nearly the opposite feelings of depression, indecision and exhaustion. For four months she felt (and her husband said she *looked*) like a tired old cat. Up to this time the baby cried a lot during the day unless she was held or rocked. Even after the crying stopped, Avis did not sleep more than two hours and Mrs. Arthur still found little time for anything but taking care of the baby and the housework. For the first nine months she felt frustrated about the degree to which she had to neglect her part-time work. She had expected to have free time for this during the day since most babies she had heard of slept for four daytime hours even at a year! After Avis started waking at night a new wave of fatigue broke over Mrs. Arthur and she was sometimes short-tempered with Avis. Then she felt guilty for she could not really blame Avis just for waking up.

During this time Mr. Arthur was very much occupied with his studies and often worked away from home in the evening. As above noted, he moved into a separate bedroom because of the baby's crying and because of his wife's fatigue. He gave up all social activities. Whereas Mrs. Arthur remained a firm adherent of ad lib principles in spite of all this, Mr. Arthur began to blame the unhappy state of affairs on lack of schedule. The babies he had heard about who were brought up on regular schedules slept!

Separation Difficulty. In view of Mrs. Arthur's persistent feelings of fatigue

it seems surprising that she did not engage help more often than she did. She left Avis with a trusted sitter only about once a week. She seemed to want to take care of the child all by herself—she was not, like her mother, going to rely on nursemaids. When Avis was nine months old, Mrs. Arthur's work necessitated her leaving town. She was in conflict whether to take Avis with her or leave her at home with the sitter, and she sought professional advice. She was advised to take a 24 hour vacation with her husband away from the child, and to use this occasion as a test for both herself and the child in each other's absence. Since Avis was reported to be good, Mrs. Arthur decided to risk leaving Avis for the two days and nights she had to be away. On her return, she was again given a good report about her child. Although she now concluded that the trouble must be largely in herself, she let things go on as they were.

At two years, Avis made "practically no fuss" when her parents left her with the sitter. One might have guessed, therefore, that six months later when her mother took her to nursery school for three mornings a week there would be no difficulty about leave taking. This, however, was not the case. Mrs. Arthur's separation difficulty is the most striking aspect of the nursery school record. Although Avis seemed ready to let her mother go after the first two times at school, it was seven weeks before Mrs. Arthur brought herself to leave Avis. She kept Avis at home the following school session, allegedly because the child did not feel well. Then began another six week weaning period for the mother in learning all over again to detach herself from her child in school. She asked the teachers for suggestions but failed to follow them. She gave overlong explanations to Avis about where she was going in a tense and hurried way, but instead of leaving immediately, she waited around and left at an inopportune time. Avis appeared bewildered. The teachers thought that Avis was absorbed in the adaptation to her mother's contradictory attitudes in nursery school and that it was difficult for her to know which one of Mrs. Arthur's expectations to respond to—whether to be a good girl and not cry, or to show by crying that she wanted her mother around. They noted that Mrs. Arthur could not leave Avis alone in her play, and that she frequently suggested starting other activities before Avis was ready to leave what she was doing.

When the family moved for the summer at the end of the third year into a community where they no longer could call upon familiar help, Mrs. Arthur found to her surprise that Avis reacted favorably to strangers and could easily be left in their care. With this realization, the parental social problems began to right themselves. The Arthurs could now plan to go out together for the evening, or to welcome friends into their home.

Guidance and Discipline. Mrs. Arthur's general avoidance of guidance and discipline appears to be the focal point in her relationship with Avis. It will be remembered that before Avis was born Mrs. Arthur expressed herself definitely in favor of the ad lib philosophy of child care. As above described, she consistently followed this philosophy in regard to feeding, crying and toilet training. This was true for discipline also. No discipline or punishment was considered necessary during the first year. Inappropriate objects for a child to play

with were put out of reach and Avis was either warned away or physically removed from dangerous situations. During the second year, the mother sometimes slapped Avis on the hands for provocative behavior, but she soon desisted, because she felt so uncomfortable and guilty whenever she was punitive to her child. But in the third year Avis again sometimes provoked her beyond the limits of her patience so Mrs. Arthur again resorted to a slap on the hand or 'bottom' or to 'isolating' Avis. At the end of the third year, when things got somewhat out of hand following the summer move Mrs. Arthur began to feel that Avis was associating punishment too much with their relationship. So she stopped punishment and scolding in dealing with the child's hostile acts and just picked her up and loved her instead. This seemed to clear the air, and it made the mother feel much better.

At the time of the third year evaluation Mrs. Arthur appeared to be completely dominated by her child and afraid to discipline her. However, she indicated at this time that she was beginning to think she had gone too far in giving Avis freedom. Furthermore, various observers had noted that in opposition to her apparent extreme permissiveness she evidenced a need to dominate her child's achievements, to interfere prematurely with her activities, and to burden her with unnecessary explanations. It thus appears that Mrs. Arthur expected too much of Avis in some ways and too little in others, and that Avis was on a constant see-saw of uncertainty between two extremes.

V Summary and Discussion

The outstanding characteristic of the Arthur record as a whole is the difference in feeling tone of the prenatal and postnatal data, and the difference in impression one gets about Mrs. Arthur before and after the birth of her child. Prenatally, Mrs. Arthur revealed herself as a happy woman, congenial with her husband, interested in her work and community activities, and in general confident in her approach to parental responsibilities, with firm belief in 'ad lib' philosophy of child care. She admitted, however, deep concern about her antagonistic feelings toward her mother. In her frank discussion of these hostile feelings, it seems probable that Mrs. Arthur was hoping to attain at least partial relief from her filial conflict before she herself became a mother.

In the postnatal data all mention of this dominant emotional problem is absent. Other problems appear in the foreground. Mrs. Arthur's happy confidence becomes replaced by perplexity over the baby's reactions, especially the waking at night strain in the marital relationship is evidenced by the fact that Mr. Arthur moves into a separate bedroom. Mrs. Arthur's enthusiastic interest in work and social activities gives way to fatigue, discouragement and helplessness. However, Mrs. Arthur did not admit her bewilderment until she was confronted with the necessity of deciding whether or not to take her child with her on a business trip.

She then asked for help and followed advice. In general, however, she sought out various opinions until she found support for what she wanted to do. Similarly, at nursery school, Mrs. Arthur initially impressed the teachers as a woman who knew definitely what she wanted and how to achieve it. Only with the separation difficulty did the inner conflict become apparent. She asked the teachers for suggestions about leave taking, but disregarded what was said to her. Although she allegedly wanted her child to develop independence, she maneuvered Avis into dependence on her and overpowered her with endless suggestions.

Rejection of her mother's domineering and "insensitive" attitude in bringing up her children admittedly determined Mrs. Arthur's interest in the "ad lib" plan for child rearing. This interest, supported by the general trend of advice in current child-care literature, became conviction. Dutifully and unhesitatingly, Mrs. Arthur carried out her permissive intentions, as expressed prenatally, in regard to feeding, crying, toilet training and discipline. She failed, however, to fulfill her intentions in one significant regard. She had declared prenatally that 'a mother owes it to herself to keep up other interests and not to become a slave to her child.' Foregoing material has revealed that for almost three years Mrs. Arthur had difficulty in leaving her child with anyone else, neglected her social interests and had to interrupt her part time work for a longer period than she had planned. Her inability to leave the child alone and her submission to the child's whims subjected the family life to a severe strain and deprived Avis of guideposts for social adaptation.

Mrs. Arthur's determination to do things oppositely from her mother dulled the sensitivity of her response to her child's needs. In overdoing permissiveness, she failed in her aim of creating a warm, consistent and secure parental environment for Avis. In spite of her efforts to be otherwise, Mrs. Arthur was, like her mother, unstable, vacillating and interfering with her child, who in turn became discontented, confused, and aggressive.

From Mrs. Arthur's point of view, Avis presented only one real problem—the sleep problem. It is remarkable that, in spite of the fact that Mrs. Arthur definitely dates both the onset and an exacerbation of this difficulty to two successive visits in her mother's home, there is no evidence of recognition on her part of the possibility that the emotional conflict with her mother—intensified as it must have been by the clash of their opposing attitudes under the same roof—played a role in the development of the problem. The available data does not allow judgment on possible explanations for this apparent postnatal change in Mrs. Arthur's insight about her relationship with her mother and in her need to

give vent to her feelings—whether, for instance, it was repressed after the birth of her baby girl, or whether Mrs Arthur consciously chose to be reserved on the subject of uncomfortable family relationships, because of uncertainty as to how information might be circulated and used. In view of Mrs Arthur's competitive attitude toward her mother, one wonders whether her relationship with Avis might not have been more comfortable if she had succeeded, where her mother failed, in producing a boy as the first born child.

The record lacks detail on the marital relationship other than the fact that prenataally it appeared to be a congenial one, and that postnatally it was subjected to strain after Avis developed her habit of waking during the night. In this connection, however, one may speculate about the reason for the development of the sleep problem, and why Mrs Arthur was unable to help Avis return to sleep after she awakened during the night. By analogy from other cases where more detailed information is available, one surmises the development of a postnatal disturbance of Mrs Arthur's marital response, which was intensified during the visit to the maternal home, and then became a factor in stimulating the child's unrest. One surmises that in Mrs Arthur's solicitous attention to the child's least cry she was unconsciously provoking Avis to continued unrest, and that the child's apparent demands then served to provide Mrs Arthur with a reasonable excuse for sleeping apart from her husband.

Except for the waking at night, the record indicates that Mrs Arthur accepted all other behavior of her child as normal. From the beginning Mrs Arthur seemed to take for granted that Avis' development would vindicate the 'ad lib' way. One gets the impression that Mrs Arthur felt that this was already the case at the time of the last report. For at three years, Avis had achieved the major developmental accomplishments for her age. She was physically vigorous, she talked fluently, she was toilet trained and she ate "mannerly" at the table with her parents. It was only in her social relationships outside the family from the outsider's point of view that there were shortcomings. It is difficult to gauge the seriousness of the child's disagreeable attitudes at three years for her future social adaptation. The reviewer has the impression that socialization has been impeded rather than irreparably damaged. At the time the record closes, Mrs Arthur had begun to accept the fact that she and her child were not wholly dependent on each other, her outlook on life appeared happier, and although she still found it difficult to discipline Avis, she admitted that her permissiveness had been overdone. If at this

time, Mrs. Arthur can begin to utilize her insight, it seems reasonable to expect that the child's social responses may expand favorably.

CASE STUDY OF SANDRA JAMES

I Prenatal, Hospital, and Neonatal Data

Both Mr and Mrs James came from families of professional people, and, at the time of the present pregnancy, both were studying for advanced degrees and working part time in professional fields. The pregnancy was planned. The Jameses had agreed before marriage that they would like to have about four children. Mrs. James was the second of three children, Mr. James the eldest of four. They wished to wait a year after marriage before having the first because of the numerous other adjustments which would be necessary. The baby was expected twenty-six months after the marriage date, which Mrs. James described as "almost on the line."

The mother made application for rooming-in two months prior to her expected date of confinement, explaining that she had read about the service in a local newspaper. She gave as her primary reason for wanting rooming-in that she felt strongly in favor of breast feeding, and believed having the baby in the room with her would facilitate this. From her reading, she had gathered that infants under the usual separate nursery system were not nursed frequently enough to stimulate the mother's milk supply, and for this reason nursing was often unsuccessful. Mrs. James expressed herself as feeling "definitely rebellious" against the idea of formula feeding, adding that her mother was coming to assist her when she returned home from the hospital, and would be distressed if she had to make formula. Mrs. James had read that breast feeding was better for the baby and promoted a more intimate relationship between mother and child. Both she and her husband were breast fed. Mrs. James described her mother as a "regular font" who nursed all her children up to one year. She said her husband felt less strongly on the subject than she did, but was pleased that she wished to breast feed. In addition, Mrs. James spoke of her desire to have the baby with her as "instinctive." Her husband also was in favor of the plan, as he did not want to see the baby "behind glass" in a separate nursery.

Mrs. James expressed herself as in sympathy with the "flexible schedule" method, and listed several points on which she would rear her children differently from the way she was brought up. She felt she had been too closely dominated and supervised by her mother, consequently, she would not discipline her children as harshly, or imbue them with fears to make them obedient. She also felt she would give her children more freedom in playing with other children of both sexes; she herself had been forbidden to play with boys.

The baby's movements in utero were enjoyable to Mrs. James because they were reassuring and gave her a strong sense of personal relationship to the child. She expressed no sex preference, although at times she felt the baby was going to be a girl. Names had been chosen for both boy and girl. Her dreams

about the baby centered around the confinement she had to go to the hospital in a hurry, the baby was born rapidly and she was conscious throughout

Mrs James' general health throughout the pregnancy was good. She experienced severe nausea during the first trimester, but she had continued to work at her job as an elementary school teacher during the first four months. After the nausea had abated, she felt "better and better". She found her pregnancy "a great satisfaction" and "no burden at all". She was extremely interested in the whole process and, because she was "an object of great interest to herself," had read extensively. Her husband was also interested and he read the same books. She felt no anxiety about pregnancy, labor or delivery, partly because she was reassured by her reading and partly because of her mother's easy labors. Her mother's three labors had been extremely short, the first lasted half an hour, the second (patient) ten minutes, the third half an hour. Her mother "would never take any anesthesia."

Mrs James' labor began at about 10 00 P.M., seven days prior to her expected date of confinement. She described the initial contractions as "little twinges . . . like menstrual cramps". By midnight the contractions were occurring every half hour, and she had a slight "bloody show," which she recognized from her reading. The contractions began to get closer together, and she began to time them. At 5 00 A.M., the contractions were three to four minutes apart. She called the doctor and she and her husband took a taxi to the hospital. She was given three grains of seconal, and at 6 00 A.M. was taken to the delivery room. She was given routine inhalation anesthesia, and thirty minutes later, nine hours after the start of labor, delivered a normal female infant, who cried spontaneously.

During the eight hours at home, Mrs James had not felt that the contractions were particularly painful. In the hospital, she disliked having to wait for the doctor to arrive, when he did arrive, she told him about her mother's rapid labors. Looking back on her labor, she felt she must have been completely relaxed, as at no time did she feel as though she "had put up a battle". She found the last two hours of labor painful but very natural and purposeful as if she were being "pushed in that direction". She did not want episiotomy and gas, and would have liked to be conscious at the delivery. The last thing she remembered before being anesthetized was saying, "I don't want that." When she awoke, she was told she had a nicely proportioned little girl. She had thought it might be a girl, and felt very peaceful and triumphant. She found the baby, who was to be named Sandra, "not very pretty, but very cute." In retrospect, she felt her optimism during pregnancy about labor and delivery was vindicated, but would have preferred not to be anesthetized.

On the afternoon of her delivery day, Mrs James was transferred to the rooming in unit, and remained there until her discharge on her eighth day post partum. She was visited daily by her husband, who was reported to have held the baby frequently, and to have shown considerable interest in the Behavior Day Sheet kept by his wife.

Mrs. James nursed the baby as she had planned. She requested that the baby

not be given any formula, so only water was used when the infant seemed dissatisfied after breast feeding. Throughout the hospital stay, the baby nursed well and vigorously, the mother was delighted at her success, because she felt it indicated the child was "precocious." Mrs. James' milk came in on the third postpartum day, and from then on Sandra began to gain weight. Mrs. James was extremely pleased with her spacing of feedings, and, as early as the first postpartum day, felt she could tell when the baby was getting hungry by the degree of restlessness she showed in her sleep. She read Spock, and commented that she felt she had a precocious child because, according to him, many children do not find their hands for two or three months, while Sandra slept with hers in her mouth.

Although she was not permitted up until her fourth postpartum day, Mrs. James asked on the day after delivery if she might care for the baby when she wished to. She was warm and affectionate toward the baby and very alert to her needs. She kept Sandra beside her most of the time, sending her to the nursery on two nights when the infant was crying and disturbing the other mothers in the unit. She slept soundly at night, and did not object to being roused to feed the baby. Evaluating her rooming-in experience, Mrs. James summed it up as an "unqualified, fundamental success."

The first posthospital month was one of alternating periods of confusion and relatively good adjustment. The first three nights at home were extremely upsetting as the baby cried and fussed almost constantly. Mrs. James thought this was because Sandra was hungry, as she herself was fatigued and excited and her milk supply decreased. However, the baby could be given neither formula nor water, since the mother had bought no bottles. The pediatrician advised the mother to offer the baby water, and to take her out during the day. He felt that the baby's self-demand feeding disrupted the family routine and that the tension was increased by the fact that Mrs. James' mother, who was visiting in the home, disapproved of such irregularity.

After this initial period, the baby became more regular, and the wakeful nights were less frequent. In the third week, however, there occurred a period of four to five fussy nights, which again caused the mother concern as to whether she had enough milk. She was reassured by the pediatrician that since the baby was on seven feedings a day, slept well between feedings, and was gaining weight, all indications were that she was getting enough to eat. Mrs. James was again advised to take the baby out during the day, which she had not done, and to offer formula occasionally at night so that she could get more rest. Formula was offered for the first time on the baby's 24th day, the baby took three ounces and slept seven hours. This convinced the mother that formula feeding was better than breast feeding but she did not want to give up breast feeding. Therefore, she still considered the use of supplementary formula inadvisable, because she was afraid she would lose her milk. However, she continued to offer the baby one bottle every day, usually in the evening because she was preoccupied with the thought that she did not have enough milk. At the time of the pediatrician's last visit, when Sandra was six weeks old, the mother's chief concern

was still whether she had enough milk. She was reassured that fluctuations in her supply were to be expected.

During the period of his visits, the pediatrician felt that there was considerable friction between the grandmother and the parents, and between the husband and wife over almost all points of the baby's care. Mr. James was very interested in the baby—as Mrs. James put it, “a little too interested to suit me.” At each visit, the mother repeated questions about spoiling the baby, feeding, airing, and dressing, and it was apparent that the parents held different views on all these points. In particular, the father asked the pediatrician to assure his wife definitely that the baby could not be spoiled at this age; he also felt his wife should offer the baby formula more frequently so that she could get more rest, should take the child out more frequently, and should not overdress her. In all, the pediatrician felt his attitude was more rational than was his wife's. He felt that the chief disturbing factor during the early weeks was the presence of the maternal grandmother. After the grandmother left, Mrs. James seemed more relaxed and at ease.

II Environmental Setting

When Sandra was six weeks old, the Jameses moved to a small house in a development which was occupied mainly by white collar workers of middle class socioeconomic status. The Jameses, by virtue of their education and university connection, were intellectually, but not economically, superior to their neighbors, and continued to associate socially with other graduate students and young faculty members. They kept up their social life after Sandra's birth, although arranging for a “baby sitter” sometimes presented difficulties. As Mrs. James explained later, she felt that the marital relationship came first, and children had to fit into the parents' lives and activities.

Mr. James was fond and proud of Sandra, but did not participate much in her actual care. As he also did not participate in the housework and as Mrs. James had no household help, the routines of the home devolved almost entirely on her. Mrs. James stated frankly that she did not care for housework, and tended to do as little as possible. This was corroborated by a visitor to the home who reported that the house was not attractive, as Mrs. James apparently was not interested in it.

When Sandra was six months old, Mrs. James suffered an unexpected “nervous breakdown,” which necessitated her hospitalization for three months. Her hospitalization followed another visit from her mother, and was precipitated by an intense paranoid delusional attitude toward her husband, which expressed itself in fears of being poisoned. Her symptoms also included compulsive reading and obsessional thoughts. Treatment revealed that her relationship to her mother and her poor heterosexual adjustment were basic to Mrs. James' sudden “break.” During this period, Sandra was sent to stay with her maternal grandmother. Little is known of this household beyond one statement from Mrs. James to the effect that she thought her mother's general attitudes were similar to her own, because neither believed in strict schedules. This statement

is, however, at variance with the pediatrician's observation during the postnatal visits that the grandmother disapproved of self-demand feeding. With electroshock treatment and psychotherapy, Mrs. James experienced a fairly rapid recovery, and was able to resume her normal life. In her subsequent contacts with the rooming-in staff, she appeared highly intelligent, quite verbal, and very well-organized intellectually. However, as a result of the shock treatment, she forgot most of the details of Sandra's birth and first six months of life. When Sandra returned home, Mrs. James hardly remembered her.

Despite Mrs. James' postpartal difficulty, the Jameses continued with their family planning. When Sandra was two and a half, Mrs. James became pregnant. She again experienced severe nausea through the first trimester, and was concerned over the possibility of a recurrence of her emotional disturbance. As Mrs. James felt that fatigue had contributed to her previous postpartal difficulty, and as the extreme nausea was quite debilitating, she spent a large part of each day during the early months of her pregnancy resting in bed.

III. Developmental History

General Development. Sandra's health during these three years was quite good. Her medical history is notable for the absence of any severe illness, or recent minor ones such as colds, stomach upsets, or trouble with teething. Specific data about her general development is somewhat sketchy. The mother's amnesia following her shock treatment prevented her recall of events during Sandra's early months, and in general Mrs. James tended to answer questions regarding development from the point of view of her philosophy of child rearing rather than in terms of the child's actual behavior. It is known that Sandra could smile and hold her head well by 6 weeks, she began to creep at 9 months, stood at 11 months, and walked alone at 13 months. She had her first word at 14 months, but did not combine words until 30 months or use simple sentences until 36 months. She could help herself in dressing by 36 months, and fed herself well by 38 months.

When Sandra was seen for psychological examination at 14 months of age, she obtained a mental age of 13.4 months. Mrs. James commented, 'We don't think she's very advanced. She tries to repeat words after me, but is so embarrassed when she can't. It doesn't seem to me that she's as eager to do things for herself as most babies I know. However, we haven't tried to teach her anything.' Sandra bore a distinct physical resemblance to her mother, both in features and coloring. She appeared as a large, blonde baby, attractive in a sturdy way. However, her attractiveness was decreased by her long red cotton dress and heavy brown shoes.

During her second year, Mrs. James tried to teach Sandra a few words so that she could "show off," but the child could not repeat them accurately, so Mrs. James abandoned the attempt. At 26 months, Sandra tested at about 24 months, again a rating of low average. She still appeared quite sturdy, but her fair, curly hair and large blue eyes gave her an appealing and attractive appearance. Again the mother expressed herself as recognizing the fact that Sandra

was not talking as much as other children of her age adding that she and her husband regarded her as an average child Mrs James did not believe in trying to push her or teach her but she tried to get her into contact with children her own age in the hope that her speech would improve With this latter point in view Sandra was entered in nursery school

Sandra's speech improved considerably during her third year though she was still quite nonverbal when seen at 38 months for psychological examination She obtained a mental age of 35 months rating as low average Her sturdy appearance persisted Although no particular item of her dress was unusual she managed to appear somewhat dowdy She was dressed in dark brown with heavy scuffed brown shoes a brown plaid skirt which was too long for her and a clumsy brown sweater

Mrs James agreed that the child was no more than average intellectually and possibly slightly below She said that recognition of Sandra's slowness had been difficult for her as Sandra played frequently with children of other university friends who were bright and it was important to her that Sandra do well However she and her husband found consolation in the fact that she was pretty and happy As Mr James expressed it She has blonde hair and blue eyes and doesn't need to worry Looking back over the three years Mrs James felt Sandra might have shown more accomplishment if she had tried to teach her words nursery rhymes or tricks but it wouldn't have been at her rate

Feeding Sandra was weaned at approximately two months when the mother's milk supply became scanty and the child's tremendous appetite necessitated a change to bottle feeding Her appetite throughout the first year was excellent she was thoroughly dependable as an eater nearly always cleaning her plate She seldom refused a food unless it was new to her and she could be brought to eat it with liking if small amounts were offered at recurrent intervals At one year her mealtimes were flexible all of her meals were eaten alone as the child preferred this arrangement She had not begun to use a cup but had made attempts to feed herself by trying to grab the spoon and began holding her own bottle around 13 months For the most part however she still preferred to be fed by her mother who characterized her as lazy and easy going by nature She showed little disposition to feed herself until the end of her second year

Sandra's good appetite continued until about 30 months when she became much more variable in her likes and dislikes and food intake and her milk consumption decreased markedly During this period Mrs James at first pressed her to eat when she felt the refused food was good for the child but Sandra became so irritable that she was permitted to leave the table to play By the age of three this phase was passing and Sandra was beginning to eat better According to the mother she ate what she should but not avidly She was eating all her meals with the parents and after a brief period around 32 months when she reverted to wanting to be fed was again feeding herself

Sleep When the Jameses moved into their new house, Sandra was put into a large crib, in a room by herself. She started to sleep through the night around three months. In general, her sleep pattern was good. There was seldom any difficulty on going to bed, and she was a sound sleeper, not disturbed by noises in the household or the presence of company.

During her second year, she had a brief spell of awakening, apparently afraid. During her third year, at about 30 months, she seemed unusually wakeful to her mother, who thought this was because she was playing more with the neighborhood children and was more active and fatigued. She infrequently called out or woke from a dream, at which times the mother went in and comforted her. Also, at around 30 months she began a period of taking various toys to bed with her, then for a while insisted on having a glass of water on a bedside table. The mother described these habits as "constantly changing," but "very definite for a time." By three years, the following bedtime routine had developed: she was bathed, sat on her father's lap briefly while he talked to her about her day or read to her, then was carried to bed either by her mother or father. She was given raisins or a piece of candy or two, and then both parents said good night to her. Mrs. James always assumed Sandra would go to sleep when she was put to bed, and did not "go in to her immediately when the child fussed a little."

Toileting Sandra's elimination throughout the three years was normal, with no problems of constipation or diarrhea. No attempt was made to toilet train her until 18 months when Mrs. James began putting her on a "toilet seat." This was somewhat upsetting to Sandra, who did not seem to comprehend the mother's purpose. Mrs. James was advised by her pediatrician to continue with the training but she felt this would involve forcing Sandra, so she abandoned it. From this point on, she was "left completely on her own" and "trained herself." By 30 months, Sandra was dry through every third or fourth night, on the others crying in the middle of the night to be taken up or because she had wet.

When playing outside, she would urinate or have a bowel movement in her clothing but if in the house, she would go to the bathroom. By three years, she was almost completely trained, indicating, "I have to go to bathroom." She still wet the bed once or twice a week, but as she now did not like to be taken up to urinate, Mrs. James ignored it, believing "time will settle this." Mrs. James said her neighbors felt it was a "disgrace" not to have trained her, and her mother thought she had been very dilatory, but she was convinced that early attempts at training would have only resulted in "a hassle."

Psychosexual Development No mention of thumb sucking, head banging, head rocking or similar behavior occurs in Sandra's history. During the first year, she removed her diaper on several occasions and played with her stool, but this provoked no reaction in the mother, and apparently was not continued into the second year. Also, she showed no inclination to play in the toilet bowl. Around three years, she infrequently showed interest in her genitalia, handling herself while in her bath, but this occurred only seldom, and was not considered

masturbation by the mother. In view of her lack of interest in genital or toilet play it should be noted that in nursery school Sandra was the only child who refused to finger paint preferring to use a brush instead.

IV Interpersonal Relationships

For all practical purposes Mrs. James' actual maternal relationship to Sandra began when the two were reunited following the mother's hospitalization. Mrs. James could remember so little of the child's early months that she felt as if this marked for them the beginning of a new life. She realized that from now on her influence on Sandra's social and emotional development was paramount.

Social Development. Mrs. James wished to encourage independence in Sandra because she felt that maternal oversolicitude was bad—it gave the child a feeling of being too much the center of things while simultaneously imposing too much adult influence on her. Therefore during the latter part of her first year Sandra was frequently left to play by herself either in her room or out doors in the backyard. She sometimes cried sharply when left alone but would then settle down to play for as long as two or more hours. Mrs. James tried to spend most of the late afternoon with her and when Sandra became old enough to walk well and not fatigue easily Mrs. James tended to make more of a companion of her. By two years they would go downtown together shopping or go to the library etc.

Sandra was extremely sociable from the beginning. Only once during her first year did she cry in the presence of a stranger. At all other meetings she looked them over with an unabashed stare then went to them readily if they talked to or smiled at her. During her second year she had more contact with children in the neighborhood. However with one exception most of these children were older than she. She got along quite well with them up to the point where they would take things from her and she would respond by pulling their hair.

Her independence of her mother was evident when she entered nursery school for two mornings a week at the age of 27 months. At her first visit she became so engrossed in pushing a doll carriage around that she did not notice or respond to her mother's good bye. This became a pattern so that every morning she went directly to the carriage allowing her mother to leave immediately. She tended to play quietly by herself with almost no variation in mood. She joined the other children for milk and crackers and for short periods of music or stories but other than this she had little contact with them. Her play in general was self initiated and perseverative in nature. She enjoyed push toys such as the carriage or a wagon. She played with a doll being quite "motherly" about it. One of her particular interests was painting; she would sit in front of an easel for hours covering the paper with long unimaginative strokes of water color.

Sandra was withdrawn from nursery school shortly before her third birthday, because of difficulties in transportation and the mother's pregnancy. In some respects, Mrs. James felt this was a good thing, as Sandra now was less supervised in her play than in nursery school. Sandra now had to handle by herself situations which arose in her play with other children, and her mother was pleased to note that she was beginning to be more self-assertive in defending her rights.

By three years, Sandra was quite independent, spending most of her day outdoors playing with the neighborhood children, who ranged in age from two to five years. Her preferred playthings were her dolls, blocks, and tricycle. Mrs. James read to her infrequently, for Sandra had little interest in books and preferred to look at pictures in magazines. She was fond of animals, particularly dogs, and enjoyed looking at pictures of them.

Guidance and Discipline Even when Sandra was small, Mrs. James began to train her to be 'a happy, social adult.' Her general approach to matters of guidance and discipline was expressed in her statement that she could be flexible on any given day, but felt that planning for certain goals in socialization was essential. Mrs. James found Sandra during her first year very easy to handle 'a pleasure and not a problem.' She was happy and usually reasonable, sensitive to the emotions of others but not nervous or high strung. She cried only in relation to some definite frustration, such as hunger, when hurt or frightened, or when tired. Mrs. James tried to handle each situation in terms of the child's need, that is feeding her, consoling her, or putting her to bed. Questions of discipline presented no problem. Mrs. James considered Sandra too young to have any definite areas of behavior of which she disapproved, saying "She doesn't want or intend to be troublesome—she just doesn't know better." On the occasions when Mrs. James had to interfere in her activities, for instance, when Sandra wished to play with some dangerous or breakable object, she tried to distract her by giving her a toy or talking to her. No physical punishment was used. Occasionally Mrs. James spoke to her harshly; this usually caused Sandra to cry, which made Mrs. James feel "ashamed of herself," because "her feelings are hurt and she doesn't understand."

During Sandra's second year, Mrs. James continued her policy of permitting the child as much freedom and independence as possible. Dangerous objects were removed from her reach, so that very little supervision and few restrictions were needed. Mrs. James continued minimizing physical punishment, and spanked Sandra only for what she regarded as two major dangers—playing with the stove and running into the street.

Although Mrs. James felt no problem of discipline existed during Sandra's first two years, she found the third year "terrible." Mrs. James said the child was "like an adolescent," because she remembered her own adolescence as a similar period of struggle for independence. Sandra's "desires of ego-self assertion multiplied" and consequently there were an increasing number of things which she could not do. Mrs. James tried to determine what were the long term goals

she had in mind for her and to deal with situations requiring discipline in terms of these. Around two and a half Sandra had begun having tantrums when she could not get her own way. When frustrated she would burst into tears, stamp her foot, kick the door or hit at her mother. Mrs. James tried to handle these situations by talking reasonably to her, but if this was not successful, told her she would be denied something she wanted or sent her to her room and shut the door. Occasionally she was spanked. Because of her resentment of the fears which had been inculcated in her during her own childhood, Mrs. James was careful never to use threats or 'arousal of anxiety' as a means of punishment. Sandra was usually quickly remorseful and would bury her head in her mother's lap, saying, 'I love you, Mummy.' Although at three years Sandra was still in a period of transition from infantile dependence to childhood independence, Mrs. James found her increasingly reasonable to deal with.

The mother was aware that Sandra was reacting to the coming baby about which she had been told for she would pat Mrs. James' stomach and say, 'Nice tummy.' Mrs. James thought that some of the changes in Sandra's behavior around 30 months were related to her pregnancy. During the first trimester when she rested frequently, she had observed that Sandra hung around her and seemed more subdued. However, all the observers who saw Sandra at three years felt they could concur in her mother's evaluation of her. 'If she continues to be the person she is now, she will be very happy. She will enjoy life, she will be herself, she will be free from distrust and self-consciousness, achieve what she wants, not take herself too seriously. She has a keen sense of humor and the ridiculous. My ambition is to keep her as sure of herself as she is now, keep her as close to us as she is now—then she will never be lonely, misunderstood, insecure. And already she is aware that she must let us have our life and our needs, and that she cannot have everything she wants because others exist besides herself. She is not in conflict with us, and I hope she never will be.'

V Summary and Discussion

The two dominant themes which emerge in Mrs. James' family pattern are those of her relationship to her mother, and to her husband. From the evidence available, it would appear that her relationship to her mother was highly competitive and markedly ambivalent. Thus, antenatally, Mrs. James stressed the differences in the way she would bring up her children from the way she was brought up; she would discipline them less harshly and she would supervise them less in their social contacts. On the other hand, her unconscious identification with her mother is evident in her attitudes toward length of labor, use of anesthesia for delivery, and reasons for breast feeding. In the latter instance, her concern as to the quantity of her milk supply suggests that she was quite ambivalent about breast feeding, but was impelled to nurse by her competition with her mother. In view of her overprotectiveness toward

Sandra in the neonatal period (overdressing, keeping indoors), it would appear that she had begun to repeat her mother's patterns in child care also. However, by the time of the child's first birthday, it was apparent that Mrs. James was carrying out her own philosophy of child care rather than following her mother's precepts. She had not begun toilet training, mealtimes were flexible, and little, if any, discipline was used.

There is some indication in the record that Mrs. James was more masculine than feminine in her interests, and may have felt competitive toward her husband as well as toward her mother. Her lack of femininity is most evident in her disinterest in keeping an attractive home and in the notably plain and unattractive manner in which she dressed Sandra. In the antenatal data and through the neonatal period, one received the impression that Mrs. James focused more on her relationship to the child than on that to her husband. In particular, the content of the pediatric home visits suggests considerable conflict and tension between husband and wife. In contrast, during the contacts with her at one, two, and three years of Sandra's life, one finds little evidence of such conflict. Instead, there is a continuance of their social life and interests together, and a feeling on Mrs. James' part that 'the marital relationship comes first.'

From the chronology of events, one can surmise the importance of Mrs. James postpartum psychosis in this reversal of her attitudes and behavior. It is apparent that this crisis and subsequent treatment enabled her to dissociate herself somewhat from her mother, and to change some of the attitudes which had been contributing to her poor relationship to her husband.

Mr. James' position in this family unit is less clear from the obtained data. In the neonatal period, he appeared more 'rational' than his wife in handling the baby, and subsequently his reported behavior toward the child suggested affectionate acceptance. It seems possible that he contributed more actual demonstrative affection in her life, and thus supplemented his wife's more detached attitude.

In retrospect, one sees in this child's life a disrupted early infancy period, followed by two smooth and uneventful years. Around 30 months, there then occurred a period of negativism and self assertion, which occasioned considerable conflict between mother and child. Although one might anticipate some such developmental manifestation around this time, in Sandra's case it was apparently emphasized by her reaction to her mother's illness during the first trimester of the second pregnancy. However, in view of Sandra's improved adjustment at three years and the fact that Mrs. James showed no evidence of recurrence of her former emotional instability, the prognosis would seem to be good.

Finally, one sees in this parent child relationship a situation in which the mother was able to give the child freedom to develop at her own rate in her basic physiological functions while imposing on her necessary restrictions for her socialization in the society in which she would live. One can speculate that because Sandra was permitted self demand learning in feeding toilet training sleep and language acquisition she was better able to accept discipline for her integration into the family group. Because of her security within her more limited home environment, she was then able to generalize this security to the larger society into which she gradually advanced. The success of Mrs. James' balanced views in self demand rearing is best evidenced by the child's apparent happiness and her acceptance by her acquaintances as a charming and likable little girl.

CASE STUDY OF GEORGIA HENRY

I Prenatal, Hospital, and Neonatal Data

Mrs. Henry's pregnancy occurring after four years of marriage was definitely desired by both parents. Although they did not feel this was the ideal time for a child, they stated that there was no perfect time to have a baby. Both believed that their major adjustments to marriage had been made and that they were emotionally ready to start a family. They hoped for three children spaced two years apart. They thought the two-year interval would allow time to get each child well started and time for the parents to recuperate mentally and physically before the next. Neither Mr. nor Mrs. Henry had had brothers or sisters and both felt they had missed a lot. They also believed that people of their social and educational level had a responsibility to society to have as large a family as they could support adequately.

Mr. Henry was a student in the theological school. Mrs. Henry, a registered nurse, had enjoyed working up to the time of her pregnancy. The work occupied her leisure time and also helped supplement their income. She did not plan to work after the baby's birth. The Henrys were living in a small apartment building with other families in similar circumstances. The addition of a baby would mean a certain amount of crowding, particularly because the baby would have to sleep in the same room with the parents, but they did not feel that this would be too difficult. The Henrys did not care whether this first baby was a boy or a girl; they chose names early in the pregnancy for both.

Mrs. Henry applied for rooming-in during her third month of pregnancy shortly after her first visit to her obstetrician. She said she desired rooming-in desperately because she had seen favorable responses from women who had been in the unit because she believed in keeping babies close to their mothers, and because she thought it was good for the father to be able to watch and pick up the baby. Later Mrs. Henry added another reason for wanting rooming-in: this plan would allow the baby to make its own schedule since she could feed

it whenever it was hungry. With firmness, she said she wanted her baby with her where she knew it would get good care. Mr. Henry was in favor of this plan, too, but left the actual decision to his wife.

When first interviewed, Mrs. Henry said she wished "desperately" to breast feed, because she thought she would feel closer to the baby from the beginning. Her mother had always led her to believe nursing was the natural way of feeding babies, and Mrs. Henry had never had doubts about nursing. As the pregnancy progressed, however, both Mr. and Mrs. Henry became a little apprehensive about the success of breast feeding, because friends had recently experienced difficulties and had to stop nursing.

During her sixth month of pregnancy, Mrs. Henry was in an automobile collision. Although no one was hurt, she felt shaken up and remained in bed for several days. At that time she became acutely aware that "something was inside" of her. Before this, she said she had always felt so well it had seemed as if someone else were having the baby. Thereafter, Mrs. Henry complained of being nervous and anxious, to a degree which seemed out of proportion to the seriousness of the accident.

Mrs. Henry reported during the last trimester of her pregnancy that the baby was extremely active, preventing her from sleeping well and causing numerous bad dreams. She was reticent about these dreams, and could seldom recall their content. She felt fatigued and restless, and busied herself continually with housework and making the baby's layette. Previously, she had enjoyed reading several books a day, now only the most popular and "easy-to-read" books about infant care could hold her attention. There were no major physical complications, however, and Mrs. Henry was essentially in good health.

In one of the later interviews, Mrs. Henry questioned the rooming-in doctor about his attitude toward a "self-demand" schedule, saying she had recently had an opportunity to observe children brought up in this way. Apparently she had begun to wonder whether a flexible schedule might not be hard on the parents. She was assured that the mother's comfort and attitude were matters of equal concern with the baby's comfort in adjusting the feeding plan.

During Mrs. Henry's last prenatal interview, she brought up certain fears about labor and delivery. She worried about the baby's being abnormal, and was afraid she might break down during labor and create a scene. She related these particular fears to episodes she had seen in her experience as a nurse. She asked questions about the meaning of various physical sensations, saying people did not tell her things because they assumed she knew all about them. She also mentioned a fantasy, starting at adolescence, that she would never have a child. The baby's movements, however uncomfortable, were thus reassuring.

Mrs. Henry's labor began with mild contractions at 11:30 P. M. on the day of her expected date of confinement. Twelve hours later, when contractions were at five-minute intervals, she was admitted to the hospital. The contractions slowed down for a while, but by 4:00 P. M. they were at one to two-minute intervals and demerol and seconal were administered. At 5:30 P. M., eighteen hours after the start of labor, Mrs. Henry was taken to the delivery room and thirty

minutes later delivered a baby girl who cried spontaneously. Elective forceps and routine anesthesia were used.

Mrs. Henry remembered the details of her labor and delivery with great clarity. In addition, she stated her concern about losing control of herself in the labor room. Another woman in the same labor room for part of the time bothered her. Mrs. Henry did not want to scream but found she could not relax and could not help making a scene. However, she had been somewhat comforted by her husband who was with her until she went to the delivery room. Although Mrs. Henry had wanted a natural delivery with no anesthesia, she said she supposed the doctor had to give her gas because things were happening so quickly, but she realized she had fought it. When she awoke and knew her baby was all right, Mrs. Henry's first thought was, "It's a wonderful relief." She wanted to hold the baby right away and was pleased that she had guessed it would be a girl and was happy because her husband would be pleased to have a daughter. On the whole, Mr. Henry was pleased that the delivery had gone so quickly. The baby was named Georgia.

Rooming-in facilities did not become available for Mrs. Henry until her third postpartal day. During the days when the baby was in a separate nursery, she nursed on a four-hour schedule. The baby sucked well, and Mrs. Henry thought Georgia got a fair amount from the breast. When Mr. Henry reached rooming-in, she began to nurse on a self-demand schedule and commented, "It's wonderful." Lactation began toward the end of that third day. From that time on, the mother began to worry about the adequacy of her milk supply and frequently expressed doubt about her ability to satisfy the baby. She often showed unrealistic concern about her own physical condition such as the amount of her lochia and about the baby's loose stools, although the doctors assured Mrs. Henry of her own good health and that of the baby. Frequently Mrs. Henry was depressed and tense because she thought Georgia was unduly fussy and was disturbing the other mothers in the room. The nurses and doctors, however, thought that Georgia was generally contented and told the mother so. Mrs. Henry was surprised and said that she was not a relaxed person.

The nurses noted Mrs. Henry's tendency to plan her day to coincide with the baby's activities but noted also that she became upset if the baby did not behave as she anticipated. Mrs. Henry said that she had wondered previously about the merits of the baby making its own schedule and that now she was beginning to feel it was not the right thing. She usually felt this way when she was tired from the frequent feedings but added that her anxiousness was balanced by the knowledge that she was building a sense of security and a closer relationship with the baby. At the time of her discharge from the hospital, Mrs. Henry thought she would try to establish some schedule by waking the baby for feedings if Georgia should sleep longer than four hours at a time.

In spite of her anxieties, Mrs. Henry seemed competent in her care of the baby and seemed to enjoy keeping Georgia sweet and clean. She told the nurses that she had wanted rooming-in primarily for the fun of actually caring for her child. Mr. Henry said he was timid about holding Georgia. He picked her up for

the first time when she was five days old. After that he seemed to enjoy holding her and feeding her formula if Georgia was hungry during his visiting times.

During the first two weeks at home, Mrs. Henry asked the doctor and the Visiting Nurse for a good deal of help, which was unexpected in the light of her own training and seeming competence in the hospital. The doctor found Mrs. Henry quite 'apprehensive,' asking him many small details about the normality of mucus, the baby's fussiness, color of the baby's stools, etc. The breast feeding seemed to be going well and very little formula was needed. Georgia cried much less than when in the hospital, and seemed to have established a fairly regular three to four hour routine, sleeping between most feedings. Fussiness occurred usually from 5 00 to 7 00 P. M. Mrs. Henry said that nursing provided periods of relaxation for herself, but the doctor thought her general tenseness was still apparent.

During the third week, Mrs. Henry became more tense and fatigued because of many visitors and relatives in the home. Her mother and her mother-in-law were visiting, and in the small apartment this created confusion. Mr. Henry was very busy with his work and unable to help. The baby's fussiness in the early evening disturbed his studying. It was at this point that both Mrs. Henry and Georgia contracted colds. By the fourth week, Mrs. Henry said she was 'too tense and nervous' to continue breast feeding, and she was sure the baby was not getting enough from the breast, anyway. When the pediatrician visited at the beginning of Georgia's fifth week, Mrs. Henry said she was extremely disappointed about giving up nursing and had cried for a whole night after her decision to stop, but she felt less nervous afterwards. It was the doctor's impression that the mother-child relationship improved almost immediately, and that Mrs. Henry now seemed more relaxed and able to get more rest. There was no difficulty with the change to bottles and Mrs. Henry seemed to be able to regulate the feedings to a fairly definite four hour schedule.

During the six weeks' examination by the pediatrician, Mrs. Henry reported that the baby was doing very well, but that she herself was not feeling 'very stable' and thought her own emotional state was interfering with the general situation in the home. She spoke of feeling depressed at times, but Mrs. Henry and the doctor both thought that she would feel better when she was able to go out more.

II. Developmental History

Georgia's general development was excellent. She smiled and laughed out loud at 3 months, sat unsupported at 5 months, and attempted to stand at 7 months. At 8 months Georgia stood alone and at 9 months she crept. At 12 months she could walk with support, was walking alone and climbing stairs at 13 months. She began to talk at 12 months and was combining words at 20 months. At two years of age she was using sentences of 12 or 13 words, was beginning to dress herself, and could use a tricycle.

Developmental examinations at one year gave Georgia a mental age of 13.5 months. I.Q. 112. Both verbal and performance ability were above her chrono-

logical age. The psychologist thought Georgia would have succeeded in some instances where her failures were marginal if her general attitude had not been sluggish due to sleepiness and teething. At two years, Georgia obtained a mental age of 2 years, 5 months, IQ 120, and at three years, a mental age of 4 years 1 month, IQ 136. Her greatest ability was in the area of visuo-manual coordination, especially with gross motor performance tasks where she scored at about the five year level.

Health Georgia's health during the first year was good, except for several colds. Her first cold, associated with weaning, was at four weeks. After that the colds were usually associated with teething. Mrs. Henry reported that Georgia seemed to catch cold easily so that she felt it necessary to protect her from cold air and winds. It seemed as if Mrs. Henry was overprotective of Georgia in other areas too. She was constantly afraid Georgia would hurt herself and was upset when she did. When Georgia was 12 months old, the mother and an observer saw her fall and bump her head. Because Georgia was frightened and did not cry for a few seconds Mrs. Henry became very excited and thought she was convulsing.

When Georgia was 13 months old, she was hospitalized for six days. The mother reported a high fever and two short convulsions had occurred at home. At the time of the admission one questionable convulsion was noted associated with a temperature of 104 degrees. The diagnosis for this illness was bronchopneumonia.

Two months later Georgia was again hospitalized because of acute laryngitis and bronchopneumonia. One febrile convulsion, at the peak of her fever, was observed. Further medical work up ruled out any other basis for the convulsions.

Georgia had a severe attack of bronchitis at two years of age, but was treated at home. During the third year the only illnesses reported were colds. Mrs. Henry continued to be very concerned about Georgia's susceptibility to upper respiratory infections, and therefore did not allow her to play outdoors on cold days or to sleep in a room with an open window.

Feeding Mrs. Henry felt that it was important for the child to establish a pattern of regularity in her feeding habits. She began in the neonatal period to regulate the schedule and continued when solid foods were added at three months to work toward regular meals three times a day. This was finally accomplished at five months. Georgia's appetite was usually above average. Foods were rarely refused, but if so Mrs. Henry would try to persuade her to eat, removing the food after a few minutes if the persuasion was unsuccessful. At 9 months a cup was used for the noon feeding and by 11 months bottles were given up completely. Mrs. Henry said that Georgia could feed herself quite well by 15 months if she were hungry, and by 20 months she was reluctant to accept help in feeding. The mother was very proud of Georgia's neatness while eating and said she didn't need a bib. When Georgia was two years old, she was allowed to decide for herself how much of anything she wanted to eat, but Mrs. Henry said, "I don't allow her to refuse food because of dislike of it." If the main dish was eaten well, Georgia was allowed dessert, but Mrs. Henry firmly stated she

did not believe in letting a child decide what is best to eat, and therefore would not give sweets or dessert until the meat and vegetable had been eaten. During the second year, Georgia refused to sit still at mealtimes and would run around the room. Mrs. Henry started using a harness to keep her in her chair, but when Georgia rebelled at this device, the only solution was for the parents to stay with her and give her their complete attention.

Sleeping. Until Georgia was 19 months old, when the family moved, she slept in a crib in the same room with her parents. After that she had a room of her own. Mrs. Henry considered Georgia's sleep patterns to be perfectly normal. She began to sleep through the night at three and a half months of age, but awoke early in the morning so that the parents began to awaken her at 10:00 P. M. and would keep her up for about an hour to "insure a longer night's sleep" for themselves. From six months on, bedtime was definite and inflexible. The bedtime routine was "short play, bath, teeth brushed, prayers, few songs, lights out." After her second hospitalization at 15 months, Georgia seemed restless and would cry out at night. The parents had to sit with her for five or ten minutes until she fell asleep. Georgia was reported to have night terrors occasionally during the second and third years, and she needed the reassurance of the parents' presence before going back to sleep.

Toilet Training. Georgia's "training" started at six months. Because Mrs. Henry noted Georgia's tendency toward regular bowel movements, she put Georgia on a "toidey seat" as soon as Georgia awoke in the morning, hoping to "catch" the movement. Georgia was removed from the seat if she did not have a movement within a few minutes. Mrs. Henry reported that Georgia "did not resent" being put on the seat and that the "catching" was sometimes successful. Suppositories were used twice, at times when Georgia "appeared to be concerned over not having a bowel movement by grunting very frequently but with no results on the toilet." At 9 months of age, Georgia was put on the "toidey seat" immediately after breakfast and after lunch every day, and "success" was reported. Mrs. Henry at that time also began putting Georgia on the seat every 40 minutes throughout the day for urination, but this was only partially successful. She continued this procedure until Georgia was 18 months old, at which time she stopped on the advice of her pediatrician because Georgia had been refusing to urinate in the toilet, and would wet her pants as soon as she was taken off. Two months later, Mrs. Henry reported that Georgia was "completely trained" and asked to go to the toilet by saying "My tummy hurts, Mommy." The mother could not date the time of night dryness, because it seemed to her as if Georgia had always been dry at night, except for periods of illness or excitement. The parents always picked her up when they went to bed, and again in the early morning.

Psychosexual Development and Fears. Occasional thumb sucking and bed rocking occurred during the first year. During the second year, Georgia occasionally touched the genital region lightly, usually during her bath, and liked to be tickled. Mrs. Henry denied any such activity during the third year, but it

was noted that she became very upset when Georgia masturbated in nursery school

The only fears ever reported by the mother occurred during the latter part of the second year Georgia was afraid of trains ever since she visited some friends who lived near a railroad track She seemed to think the trains were going to come off the tracks and harm her Vacuum cleaners also frightened her

Social Development Throughout the first year the records describe Georgia as 'healthy, happy, sociable relaxed affectionate friendly, agreeable and adjustable and note that she was rarely fussy or irritable and did not cry very much There was one irritable period at 8 months when Georgia objected to being in a room alone and another at 10 months when she was reported to cry whenever the mother was out of sight At 12 months she was friendly to all strangers if she were allowed to make the first approach The parents thought she showed a lot of independence for her age and that she had a definite mind of her own but that she was adaptable and easily pleased

After her hospitalizations in the second year Georgia seemed nervous and cried easily After moving to their new home Mrs Henry thought Georgia was very anxious about the parents whereabouts and was upset if she called and one of them did not answer her immediately She began to demand excessive attention from her mother Mrs Henry thought Georgia should play with other children but said there were no suitable companions in the neighborhood Whenever Georgia did play with other children Mrs Henry said she got along well would take turns easily and enjoyed herself However when observed at two years Georgia seemed unspontaneous dependent upon her mother and only grudgingly complied with requests Mrs Henry said Georgia would accede to requests at home only if they made up competitive games so that Georgia could have an opportunity to win over the parents

When Georgia was 32 months old she was entered in a nursery school for several afternoons a week The teachers noted from the beginning that Georgia was the most disturbed child in the group She was ambivalent toward the teacher assigned to her alternating between demanding a lot of attention and being hostile to the point of attack She was openly aggressive toward the children and jealous of their relationship to the teachers There was a great deal of anxiety about toilet matters such as wanting the door closed or wanting affection after she had used the toilet She was also disturbed if she spilled water on herself or got clay or paint on her hands Her baby talk was in striking contrast to her size age and general motor ability There was no problem of separation however and Georgia did not need her mother after the first half day

Georgia's adjustment in nursery school became even worse when Mrs Henry told her she was pregnant She got a cold was absent from school for a few days and on her return was excessively demanding competitive and hostile Georgia was told of the pregnancy (definitely planned) quite soon because Mrs Henry had to restrict her from some of their usual play together Georgia was "too rough and would hit her mother in the abdomen Toward the end of the third

year, Mrs. Henry described Georgia's "regressive" behavior at home and seemed to think she had picked up her "bad habits" of aggressiveness and "selfishness" from the children in school. She thought Georgia was not learning enough because she was not tired out when she came home. Accordingly, Georgia was withdrawn from nursery school.

Mrs. Henry also complained of Georgia's constant demands for love and attention, but seemed to think these demands were more related to her need to restrict her than to Georgia's feelings about having a sibling. Mrs. Henry described Georgia's "rituals" and routines, and her general stubbornness. For instance, Georgia would insist that everyone walk around his chair three times before sitting down to eat, or that they all should eat with the left hand. If her orders were disobeyed, she had a tantrum. At three years of age, Georgia was unable to play well with other children, would not play by herself, appeared unhappy, whiny, petulant, impatient and demanding. She cried at the slightest frustration, and was reluctant to approach anything of difficulty.

III Interpersonal Relationships

Parental Attitudes and Relationship Throughout the records of the first year, Mrs. Henry is described, in striking contrast to the way Georgia is described as "nervous," "anxious," "apprehensive," "tense," "upset," "unstable," "unhappy." She felt extremely fatigued for the first five months of Georgia's life, was easily depressed and discouraged, especially if things could not be done at the moment she wanted to do them. She constantly felt inefficient and inadequate. She thought her attitude toward the child was abnormal, and said the only time she felt close to Georgia was when Georgia was ill or needed her for some specific purpose. She felt that the child was interfering somehow with her relationship to her husband, and although she did not want to put the child ahead of her husband, this was happening. She felt she was losing control of herself, losing her sense of judgment, and saying things she did not mean and thus disturbing her husband. Because of the pressures of his work, Mr. Henry was unable to participate much in family activities or to have any leisure time with his wife. He developed symptoms of peptic ulcer and had to go on a strict diet. Mrs. Henry ate the same diet for the sake of convenience, resented it, but also felt it was only fair because she thought her reactions had contributed to the development of the ulcer. Their cramped living conditions created further dissatisfaction and unhappiness.

When Georgia was 12 months old, Mrs. Henry became so "nervous and upset" that she considered psychiatric treatment. However, after making preliminary investigations she decided against it, saying psychiatrists were for the seriously mentally disturbed people, and she thought she would try using more "common sense" first.

A marked change occurred shortly after this. When Georgia was hospitalized for six days at 13 months, Mrs. Henry took this opportunity to get out more, and to get more rest. The fact that Georgia then needed her as a nurse, as well as a mother, gave her great satisfaction. When Georgia was 19 months old, Mr.

Henry became the minister of a church in another community and they now had a home of their own Mrs Henry enjoyed participating in various church activities Although Georgia demanded a lot of attention at this time baby sitters were more easily available It seemed as if Mrs Henry thrived on the pressure of her activities and that they provided a necessary distraction from her problems There was little warmth apparent in the mother child relationship and Georgia, who was a bright child seemed to serve only as a source of ego satisfaction to the mother

When observed infrequently with Georgia at nursery school Mr Henry seemed to the teacher more relaxed and warmer with her but on one occasion he reprimanded Georgia severely because she had used the toilet with the seat up sitting with her buttocks in the water He told her this was a dirty habit and she should know better because they had told her this at home

Throughout the third year of Georgia's life Mr Henry was able to spend even less time with his family and Mrs Henry continued to feel her church duties came first She assumed additional responsibilities for groups which met frequently in her home During these meetings Georgia was restricted to her own room or sent outside with a baby sitter When Mrs Henry became pregnant she became increasingly fatigued and was less and less patient with Georgia At the end of this record there is little to indicate a satisfactory relationship between Georgia and either parent

Guidance and Discipline Mrs Henry's methods of regulating the feeding schedule of starting toilet training and of setting bedtime limitations indicate her desire for a well ordered household and her need for her child to be like herself efficient and well scheduled It is apparent that the parents' needs and rights were primary and that Georgia was expected to fit into their patterns Mrs Henry however considered her methods flexible and said Georgia was relaxed and good humored during the first year because of their attitude of not forcing anything

The mother was constantly afraid Georgia would hurt herself she tried to teach Georgia to avoid dangerous situations such as the stove stairs and street by warning her of the hazards involved or by spanking the dog as an example Georgia however had learned about the stove the hard way When quite young she had been burned by falling against a hot stove and never had to be warned again A fence with a gate impossible for Georgia to open prevented her from running into the street and Georgia was not allowed outside the yard without adequate supervision

Punishment started at about one year consisted of spankings for eating paper or wood for deliberate destructiveness for handling objects not allowed her and for getting up and down from her chair at mealtimes Sometimes Georgia was sent to bed until she could assure the parents she would be good The threat of refusing to allow Georgia to do something she wanted to do very much or of taking away a desired object was also used but Mrs Henry did not consider these methods of punishment successful

The success of Mrs Henry's attempts to guide Georgia's socialization may

be judged from Georgia's visits by herself to her maternal grandparents. They reported her good behavior, saying she ate and slept well and never broke anything while at their home. Mrs. Henry was pleased to have Georgia visit, and said she did not worry about their spoiling Georgia, because her mother agreed with her on the major aspects of child care.

Over and above Mrs. Henry's personal need to guide and discipline her child, she thought their social position made it imperative for Georgia to be "clean, bright and well-mannered." At two years of age, Georgia was being taught colors, nursery rhymes, and how to count, and Mrs. Henry insisted that she say "thank you," and "please" and practice other such small courtesies. She was supposed to put her toys away, and Mrs. Henry believed it was essential for Georgia to distinguish her things from the parents' possessions. Most of her toys were of an "educational" nature. Mrs. Henry objected to Georgia's use of clay and paints, and was upset whenever the child was messy. In general, observers felt that Georgia's welfare was sacrificed not only to the marital relationship, but to the social and professional status of these parents in their community.

IV. Summary and Discussion

Mrs. Henry's rigid attitude and need to control dominate this record. When first interviewed, she seemed to want to present a picture of leniency and permissiveness, but it soon became evident that such an attitude was impossible for her. The fact that Mrs. Henry had chosen nursing as her profession might indicate an even earlier desire for routine and efficiency. It has been shown that she became emotionally upset whenever she seemed to be losing control of the situation. Mrs. Henry, herself, dates the onset of her "nervousness" to her accident during the sixth month of her pregnancy. However, she also reported it was at this time that she first became vividly aware of the reality of the pregnancy. It seems plausible to assume that her nervousness was due to her awareness of the existence of an independent being within her, rather than to the accident itself. As the pregnancy progressed and the fetus became more active, Mrs. Henry became more tense, restless, fatigued and had bad dreams. She was upset about her behavior during labor when she could not keep herself from screaming. During the hospital period, her former doubts about the value of "self-demand" crystallized, and Mrs. Henry decided to use a four-hour schedule of feeding. In the neonatal period, it was noted that Mrs. Henry was more relaxed after she stopped breast feeding, and could better control the time and quantity of feedings. Her fear of losing control was so great when Georgia was one year old that she considered psychiatric treatment, but rejected it because she did not want to admit she could not help herself. During Georgia's second year, Mrs. Henry found an outlet for her needs in the child's illnesses and in her own activity in church work. When Mrs.

Henry became pregnant during Georgia's third year and Georgia demanded more of her, the mother was again upset, impatient and fatigued

Georgia's susceptibility to illness is noteworthy, in view of the fact that Mrs Henry said that the only time she had the feeling of "maternal love" was when the child was sick. A review of the record has shown that Georgia tended to respond to withdrawal of her mother's attention by becoming ill, thus creating situations where she received more love and care. One can only speculate about the choice of the upper respiratory tract as the focus of the illnesses, but it would seem significant that Georgia's first illness, a cold, was associated with termination of breast feeding, the first experience for her of her mother's withdrawal. By three years of age, Georgia was so "susceptible to colds and bronchitis" that Mrs Henry was constantly solicitous of her.

The outstanding characteristic of Georgia's history is her poor social adjustment after the first year. It would appear that this was related to the degree of control which the mother could exercise over her. Thus during the first year when Georgia was in a stage of infantile dependency, there were no observable difficulties. During the second year, her illnesses provided the dependency necessary to satisfy the mother's needs, but problems appeared in other areas such as toilet training and sleep. During the third year as Georgia became more independent and self-sufficient, the mother became increasingly demanding and rejecting of her. At three years, one sees an unhappy child who is regarded as a real "behavior problem." However, it is to be noted that, at three years she is able to utilize her superior intelligence, probably because she is rewarded in this area by her mother. Mrs Henry's rejection of psychiatric treatment, her solution of her conflicts through increasing rigidity, and the impending birth of a sibling lead one to prognosticate an increasingly difficult situation for the child. One would anticipate that Georgia would react with increasing resentment and rebellion.

CONCLUSION

These three cases chosen for their similarity in background reveal striking differences. Although the three mothers had been exposed to the same philosophy of child care the records show that each applied it differently in practice. It is apparent that Mrs Arthur overresponded to the permissive aspects of a self-demand philosophy and was unable to set limits for her child. Mrs James was able to adopt a middle-of-the-road attitude, giving her child freedom to develop at her own rate while simultaneously imposing the necessary limits for her socialization. Mrs. Henry thought of herself as a permissive mother, but was actually inflexible and made premature and excessive social demands on her child.

Although it would be impossible to prognosticate the eventual outcome for the children, one sees in them at three years different types of social adjustment. Only Sandra James appears as a happy, likable, well-adjusted little girl, able to generalize the security she found in her home to her wider social contacts. Avis Arthur and Georgia Henry, the children of the most divergent mothers, were similar in their social maladjustment. Avis appears as a discontented, "spoiled," and demanding child, bewildered by the lack of consistency in the direction of her behavior. Georgia appears as an unhappy, sullen, aggressive child unable to cope with the normal pressures of society.

The case histories indicate that the basis for the divergence in attitude of the mothers is to be found in their own background of experience and interpersonal relationships. It appears that Mrs. Arthur was reacting against a very strict, overpossessive and domineering mother in wanting to assume the opposite course with her child. Mrs. James, although initially disturbed by her relationship to her mother, apparently profited sufficiently from her psychotherapeutic experience to enable her to separate her own emotional problems from her handling of the child. Although the information on the Henry family relationships is less adequate, there are indications that Mrs. Henry tended to identify herself with her mother and repeat with her child her own pattern of upbringing. One can surmise that, paralleling these differences in identification, there were differences in the marital adjustment of the three women. In the Arthur family, it seems apparent that the mother sacrificed the marital relationship and parental rights to the rights of the child. In the Henry family, one sees a situation in which the mother sacrificed the rights of the child to those of the parents. Only in the James family does one find a balance in the recognition of the rights of both child and parents.

In comparing the cases of Avis Arthur and Georgia Henry, one is led to speculate about the relative traumatic effect of insistent permissiveness and extreme rigidity in parental attitude on a child's developing personality during the first three years. The question arises as to whether, with modification in maternal attitudes, the young child cannot recover more readily and with less distortion from the confusion of undefined limits than from the pressure of prematurely exacting demands. While recognizing that both extremes of maternal attitude are alike rooted in ambivalence, the authors incline to the belief that the ultrapermissive mother may be more readily susceptible to change through therapeutic influence and cultural pressures than the ultrarigid mother. In the present cases, therefore, one would prognosticate a better personality adjustment in the future for Avis Arthur than for Georgia Henry.

THE USE OF PSYCHOANALYTIC CONSTRUCTS IN PREVENTIVE PSYCHIATRY¹

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I

The development of the quest to find preventive methods in the field of psychiatry has been strong since the last war, when deliberate planning in the reduction in the rate of incidence of psychoneurotic casualties became a necessity and on a few occasions a reality. The remarkable success which psychiatrists have witnessed with the control of somatic diseases, especially contagious diseases, such as typhoid fever, in the larger field of preventive medicine added impetus to the field of psychiatry. In the field of organic brain disease the marked reduction in the incidence of general paresis since we have an organized program for the control of venereal disease is a striking example for such possibilities.

In the field of the psychogenic disorders, namely, the neuroses and behavior disturbances, we are still far from attaining such a goal, notwithstanding the fact that a relatively vigorous mental hygiene movement has been carried by interested citizens and professional people for almost fifty years. Kubie (1948) has recently pointed out how penetrating and systematic efforts at preventive work would have to be in order to assure noticeable effect.

We believe, as Kubie does, that the psychoanalyst is the logical person to initiate efforts in preventive psychiatry because from his clinical experience he has immediate acquaintance with the natural history of the neuroses and personality disorders and his theoretical orientation is directed to the early antecedents of neurotic development which might well be discovered and handled with relative ease if the proper machinery were developed to do so. On the other hand, the analyst is impeded by the relatively small number of patients whom he comes to know well.

¹ Presented at the meeting of the Boston Psychoanalytic Society on November 23, 1951

Moreover, he is accustomed to deal with a very large number of etiological variables in single individuals and is less inclined to assess the relative pathogenic potency of a specific variable or a manageable constellation of variables.

It seems to us that we will progress in the field of prevention of pathogenic disorders only if we succeed in developing a working relationship between psychoanalysts and epidemiologists and between psychoanalysts and social scientists. The epidemiologists are accustomed to ascertain and scrutinize differential rates in incidence and prevalence of conditions of ill health. They contribute the concepts of host, agent, and environment, as well as those of contagion, transmission, and readiness or immunity to infection. The social scientists have undergone a remarkable development in the last two decades, partly, to be sure, under the influence of psychoanalytic thinking, and are ready to search for answers concerning the baffling problems of the relationship of personality organization to the structure and function of the social systems in which the individual has to operate. Talcott Parsons' (1951) recent contribution, *Toward a General Theory of Action*, in a study with the members of the Department of Social Relations is a striking example of such efforts at the level of comprehensive theory.

Our own interest in the field of prevention was stimulated by observations on various forms of grief reactions in which it became quite clear that minor differences in the management of the emotional adjustment immediately following the bereavement might have forestalled a neurotic development which lasts for years (Lindemann, 1945). The discovery that bereavement plays a very significant role in contributing to the development of certain severe psychosomatic disorders such as ulcerative colitis and rheumatoid arthritis (Lindemann, 1950) added to the desire of finding methods of ascertaining early enough the personality make-up of vulnerable individuals and the constellation of human relationships which must be preserved to guarantee their psychological health. If it were possible to screen the "normal" population for the presence of vulnerable individuals true preventive work might be possible.

It soon became evident that to get access to the normal population one has to become well acquainted with a community of a manageable size. Fortunate circumstances made it possible to use a Boston suburb, Wellesley, for a project in preventive psychiatry. In order to have a solid foundation for our work in the community, it was thought wise to develop a plan of organization which would provide for a series of joint committees consisting of interested citizens and staff members as resource people for the solution of the problems which the citizens would raise. There was also an executive committee made up of citizens at large to

whom the joint committees reported for the purposes of integrating the work and assigning priorities

Among the basic assumptions on which the members of the staff agreed were the following

- 1 A large number of emotional disturbances can be explained as the effect of crises in an individual's emotionally relevant human environment
- 2 The reaction to the present environment is to a significant degree determined by the degree of disparity between interactional requirements and interactional opportunities
- 3 Interactional requirements are likely to be the result of the interactional opportunities of the years of childhood development the presence or absence of so called social skills will be determined by the presence or absence of early interactional opportunities which facilitate social learning
- 4 While frequency and duration of interaction and their distribution among emotionally relevant individuals is important the organization of interaction patterns according to the role expectations of the various members of an interactional system will allow predictions as to good or bad emotional adjustment of one or several members of this system

While all members of the staff agreed that these considerations were important there was considerable disagreement concerning the relative significance of such considerations as compared to the theory of libidinal development ego structure and the effect of traumatic experiences The above set of statements is slanted toward the system of human relationships which may be hazardous or suspicious for mental health The intrapsychic development as seen from the psychoanalytic point of view was obviously of parallel importance the internalized early environment making the greatest difference for the choice of later human constellations Indeed the development of specific types of preferred human relationships designed to satisfy basic needs as to permit the compulsive repetition of unsolved interactional problems is one of the most significant aspects of personality structure so far as mental health is concerned It was also decided that factors of physical health although presenting variables to be controlled were not a primary focus of the work

It was decided to start our program with two aims One was the macroscopic approach using epidemiological frames of reference and trying to relate the distribution of emotional disturbances to differences in the areas and sections of the community predicting higher rates of occurrences in certain stress areas lower rates in stress free sections. This

plan involved an analysis of the community into relatively homogenous sections with high interaction within the section and low rates of interaction across the boundary into other sections. Ethnological differences, differences in income, differences in cultural background, differences in age distribution, and finally, the relative mobility of a population were considered as useful marks of distinction (We finally chose three sections, all centered around a school, each having markedly different population characteristics, in order to look for differences in the type of disturbances to be found.) It would be possible, we thought, in this manner to contrast a high income, estate type section with a medium income, residential home section, and a multi family housing section with relatively low incomes for this community. Of special interest, we felt, would be isolated families and individuals of different backgrounds and different resources in a given neighborhood.

The case finding program to ascertain the number and types of emotional disturbances soon proved to be very difficult. At the very least it required an agreement on what to look for and on methods of case finding. It was clear that it would not be enough to collect cases of major psychoses from the records of surrounding mental institutions and of cases of criminality or of social breakdown (divorce) from neighboring courts if our aim was preventive. Our plan was to collect the so-called minimal disturbances and to see which of these are signals of later severe disease. This meant getting information from other professional groups and agencies concerned with human relationship problems to learn about crises which would not lead to breakdown and about emotional disturbances which were mastered successfully because of the special resources of the individual or because of a change in the circumstances.

The best way of learning about these matters seemed to be the avenue of rendering service to the various professional groups through consultations concerning a variety of crises which they had to handle, and this effort became indeed a significant part of the overall service program.

Our aim was not to form a clinical facility for the purpose of long treatment of a small number of cases but rather to provide a mental health agency to assist families and other types of groups in times of emergency and help them design a program of action at the most suitable level. Who in the group was the patient was often an unanswered question. The emphasis was on pathological relationships, manipulating other individuals found to have pathogenic effect upon the so-called patient might be much more important than the person with which the initial complaint was concerned. An alteration of the system of human relationships to which the alleged patient was exposed might turn out

to be useful not only to him but to a number of other members of the group who did not happen to present themselves as patients

This meant that there had to be a core of traditional therapeutic facilities but attention had to be distributed to the various members of the family and of other social groups, referral to other treatment sources would often have to be facilitated and effective therapeutic contact would have to be limited to the immediate crisis, followed by a plan of action of more preventive type designed to forestall the reoccurrence of the pathogenic crisis. The evaluation of danger signals discovered by accident in certain social orbits and the utilization of a variety of channels of communication for the most effective manipulation of a given group brought many problems for the judgment of both psychiatrist and social scientist. Thorough acquaintance with the mode of operation and the set of values which determined the action of clergymen in different denominations, educators in the public school system, medical practitioners and law enforcement personnel was required in order that we might predict the ideal mode of handling a situation and suggest only such motivations as would be compatible with the good will and tolerance of the various professional groups. It became necessary, therefore, to have at regular intervals meetings with the professions to compare points of view, the folklore of the profession about problems and emotional disorders, and to compare and translate from one jargon to the other the major assumptions and customary lines of management. We had all clergy including the Catholic with us for such meetings and professional consultations. They became the opportunity for inquiry about the problems under the actual care of a clergyman and about those in the neighborhood about which he knew.

A then somewhat unexpected job, combining opportunities for social and for research was the maintenance of a tolerable human environment for former patients in mental hospitals and for patients partially recovered from an emotional breakdown. These efforts closely related to what is called rehabilitation in public health circles mean advice to family members, friends, and neighbors of individuals who are mentally or emotionally impaired and whose extravagances have to be absorbed by those in their human environment. Brief contacts with key persons in these groups may turn their moral indignation and suspicious withdrawal into interested acceptance with reservations.

It is now possible to describe our more detailed investigative efforts beyond the broad epidemiological approach mentioned at the beginning of this paper. We were interested in the factors in the family and in other small groups of relatively stable and enduring type which might contribute to the hazards for the mental health of its members.

It is necessary here to consider the area of mental health which seems to be accessible to investigation. This includes mental derangement, physical symptom formation on an emotional basis, a deficit in the performance of specific tasks in relationship to a person's equipment and deviant behavior sufficient to provoke punishment. On the positive side of this, we added the capacity for creative participation in joint enterprises and the sense of well being. We are much interested in Erikson's (1950) and Jahoda's (1950) formulations concerning personality development along healthy or unhealthy lines. With these criteria we were interested in finding manifestations in the course of the life cycle which were signals of more serious disturbances to follow. We were also interested in factors which make for relative immunity to impairment in the face of disturbing and traumatic situations.

These situations were conceived predominantly as crises in social interaction, the thesis originating in the author's studies of bereavement, showing a variety of reactions to abrupt changes in the rate of social interaction with at least one other individual. We became interested in the effect of minor changes in social interaction as brought about by geographical removal, change of location in the social system, temporary exposure to new individuals, rupture of relationships by disillusionment, and drastic change in role. It was hoped that study of the several members of a social unit at the time of such a crisis might throw some light on the factors which increase and those which reduce the capacity for adaptation. An initial study for this purpose was an analysis of families in which one member had to be hospitalized because of mental derangement. These became pertinent questions: does the change in behavior occur in only one member of the group? Are there changes in behavior patterns in other members also? What type of adjustive phenomena can be noticed in the distribution of roles within the family? And what kind of phenomena preceded the final breakdown?

A second area was the investigation of minor crises in child development, especially those inevitably occurring in the life of the child. We focused our attention on two specific areas.

Nursery school aged children are likely to show periods of aggressive self assertion and are likely to be of concern to their mothers in connection with problems of discipline and the control of aggressive behavior. It seemed of interest to study the mother's adjustment to this task in the light of her educational and child rearing background and in the light of the agreement or disagreement between the mother and father concerning the desirable code of conduct. The distribution of the father's interest between work and family concerns was also described, giving a

picture of middle class families as they master a specific problem in normal child development

Another important phase of child growth of possible consequence for later adjustment seemed to be the crisis of entering school. In this area it was possible to combine the beginnings of a service program with a plan of study designed to increase theoretical insights. This part of the work has been described as the 'preschool clinic'

For several years before our arrival it was keenly felt by the citizens of the community that some method of screening out children in need of psychiatric help and some method of predicting future difficulties might be highly desirable. The behavior profiles for screening purposes had been tentatively handed to the teachers and had not proved successful. It fell upon us to design a plan for securing an initial record of the psychological and social circumstances affecting the life of the child about to enter school. It seemed intriguing to try to make predictions from an initial record for probable signs of impairment in social adjustment during the first years of school life and to ascertain what really happened by a system of follow up observations both in school and in the family. To implement this plan, the staff participated in the examination at registration time, adding to the parent teacher interview, parent physician interview, parent dietitian interview, and parent dentist interview, a so-called 'guidance' interview which was designed to win over the parents for a more thorough study at a later date. Our first effort in this field may be described as a pretesting period consisting of four interviews with the mother and one or two interviews with the father and by behavior samples of the child during a Binet Simon test, in a doll play situation, in a productive art situation, and in group play with other children. A description of the child's social system of the parental aspirations, the essential child rearing techniques and the crises in previous human relationships. Whether or not information gained by such a brief contact can serve as a basis for valid predictions and can prove useful for back reference at the time of later trouble is a matter of great interest for the development of any mental health program in a school system. Much effort is being spent in devising the kind of interview which is most productive and circumventing the problem that mothers of children who consider themselves and the child healthy may have little motivation for revealing any untoward circumstances. The problem of competition for the greatest degree of 'normalcy' was unexpected and seemed to be a strong motivating factor. Similar problems arose in connection with the examination of the child. Which kind of behavior sampling is the most revealing? Under what circumstances is it best obtained? How useful are projective techniques in contrast to behavioral observations in a situa-

tion involving another child? What behavioral categories are the most useful? We cannot go into detail about this study at present and I do not wish to discuss its relationship to the numerous studies in child development which are available in the literature. The important focus for our own concern is the subsequent observation of teachers in the school and parents in the home and information about fluctuations in adjustment which may give clues to the child's over all emotional growth.

The problem critical for preventive psychiatry was the question of whether or not it was possible to make reliable predictions from a preschool interview about the subsequent behavior of a child in his school and home situation. We thought it important to focus on the age four and a half to six years because it presents one of the critical periods, as Robert Waelder (1941) has pointed out in a recent paper, namely, when there is a shift in the relationship between ego strength and libidinal pressure. The mastery and the dissolution of the oedipal period and its replacement by the less obvious personality growth during the latency period seemed of more than merely practical interest. The strides which have been made in ego psychology through the work of Thomas French, Robert Waelder and Ives Hendrick (1943 a, b, c) have brought the theoretical frame of reference closer to that of the educator and psychologist. The learning process, the ability to master and integrate complex situations without interference from unsolved emotional problems, and the distribution of libido between narcissism and object relations seemed to us to be a core problem of developmental psychology.

In order to develop a measure of ego strength we used the concept "task orientation" meaning by that the child's preference for the execution of a self selected task in contrast to dependence on adults or affectively charged repetitive behavior. Observations of the child in a doll play situation where a great many toys were accessible seemed to be a suitable method for circumscribing and ascertaining the degree of task orientation present at the time of the preschool clinic examination. Just how predictive are such observations for subsequent behavior of our children in the kindergarten group of which the previously observed children were members? This question had to follow because individual task orientation may be strongly influenced by the behavior of the other children and the leader. Both the individual laboratory observation and the group observations studied in the light of interview material obtained from the mother concerning her own emotional adjustment, her perception of the child, her aspirations for the child, and concerning crises in the human relationships, especially losses of significant persons, formed the basis for our efforts to map various forms of ego development in this critical period.

This paper is actually premature because our data are not completely collected and our findings are not conclusive enough to add significantly to our body of information. It seemed useful however, to describe this study for the purpose of assessing a normal population as complementary to the type of clinical observation as described below

II

The scope of this project has been outlined in the preceding part. It was necessary to educate a whole community before the sources needed for our study were mobilized and available. There was a great deal of spade work done before the background preparation was accomplished. The educational work was done by members of the project. The schools, the PTA groups, the churches, and the parents individually and collectively, were contacted. Soon the public health aspects of preventive psychiatry as applied to the growing child became apparent. The community responded with gratifying enthusiasm.

Interest on the part of the school teachers led to their full co-operation with the project, when the preliminary study of the preschool group was set in motion. In this study an attempt was made to ascertain the number of children who showed behavior deviations before entrance into school. Such children were tagged. The decisive figures in the home were interviewed and information about such things as the position of the child in the family, the number of siblings whether the child was wanted or not etc., were collected. Psychological studies were also done. A careful developmental history of each child was compiled.

As these data were being collected the educational work with the schools resulted in an increasing number of children in the six to twelve age group being referred to the project. The doctors and clergymen in the community also began to refer parents who came to them for advice. Children in the six to twelve age group were more frequently sent to us than the younger children were.

It became evident that by closer study of the latency group from six to twelve, we could look with sharper eyes for the prodromal symptoms i.e. the behavior deviations in the preschool child. Each careful history accompanied by a concomitant study of the child the parents the home and the school revealed that the trouble had started in the preschool years but had not been recognized.

The impact of this discovery and the overwhelming number of children referred in this six to twelve age group led us to focus our study on these children in the latency period. We feel that teachers of this age group are in a key position to help the psychiatrist when he and the

social worker are working with the child and his parents to recognize and to correct undesirable symptoms which, if left untreated, would threaten his future health. The strength of social pressure on this now sophisticated community forced other parents to bring their children to us. It is interesting to note in passing that we have had very few adolescents in this study, because, for the most part, they did not want to come. No special effort was made, therefore, to bring them in.

At this point it may be worth while to consider the difference between the neurotic adult, and the neurotic child. Anna Freud (1946) says, "The adult suffering from a neurosis seeks help. The extent of the crippling caused by his neurosis can be assessed both subjectively and objectively. The adult seeks help when either his ability to love and enjoy his sexual life is interfered with, or his working capacity is affected. In contrast to the adult, the neurotic child, as a rule, does not experience suffering; it is those in his environment, or his parents who complain. In some neurotic disturbances of children, when a somatic solution for the conflict is found, e.g., bed wetting, soiling, colitis, neurotic vomiting, or asthma, the element of subjective suffering is introduced." We realize, to quote Anna Freud again, that "the sexual life of the child is no less extensive and certainly no less intensive than that of the adult. . . . When the child enters school at the age of six, the first severe repressions of early childhood have occurred. The child's sexual drive is centered around the objects in the oedipal conflict, but the sexual life of the child is diffuse in its manifestations. The component instincts are in the foreground, the genital primacy has not yet become established. According to his nature, the child is "impotent" in his sexual activity. This means that the intactness of his sexuality is much more difficult to gauge than that of an adult." This last point is extremely important because "it is difficult to measure the child's capacity for object love. We can measure only the libidinal urges which are directed toward the outer world against the narcissistic tendencies of the child." As Anna Freud has said, after the first year of life, "Object love should outweigh narcissism. Satisfaction derived from objects should be increasingly greater than auto-erotic satisfaction," as the child moves along the developmental curve toward maturity. Infantile neurosis seriously interferes with these proportions. It is extremely difficult to assess these proportions because of many subtleties which come into the situation.

"In assessing the neurosis of an adult, one takes into account his working capacity. There is no parallel to this in the life of the child. The only thing we can say is that play is as important for the child as work is for the adult." Consequently, it is an accepted fact by workers in this field that a child's inability to play is highly suggestive of the extent

of its neurotic disturbance. We who have worked with neurotic children agree that they are invariably disturbed in their play activity. But Anna Freud noted also the importance of the fact that imaginative play which is excessive at the expense of constructive play is also a neurotic solution. In the initial stages of this type of imaginative play the parents often consider that their child is especially gifted that he has wonderful powers of imagination and great artistic ability. Neurotic elements stand out when the play becomes repetitive or monotonous or interferes with other types of activity. The average modal child uses play to master skills as well as to master new or difficult life situations. The child makes a progressive curve from blocks to tinker toys to the increasingly complicated patterns in relation to play material.

Since play is governed by the pleasure principle and work by the reality principle, disturbances of these two functions are of different clinical significance. So we would say that it is impractical to apply the same criteria for the evaluation of a childhood neurosis as in the case of an adult because the two types of neurosis are very different. It would be better to say that in the child the onset of neurotic disturbance coincides with stasis of the libido. Instead of moving forward to adult levels the libido has been forced backward and important gains have been undone.

The average child in the early years before five shows at times disturbances in his relationship with the mother but such disturbances are transient not constant as in the case of the neurotic child. The way such disturbances are handled by the decisive figures i.e. in home and in the school is of great importance in the child's management of them. For example many children are poor eaters at some time in their lives. Often at two to two and one half years when the child actually begins to need less food the mother's hostility is mobilized probably by the anal components in the child which are uppermost at this time. The mother scolds the child for dawdling and talking at mealtime. She forces food on the child and often creates a problem which need be no problem at all. Once fight and force has been introduced into the mother-child relationship it is very hard to eradicate this reaction pattern. The mother's frustration provokes her to nag and the child's frustration provokes him to resist. If he is able to comply with his mother's wishes he may develop especially obstinate patterns which fan out to reinforce the problem of the toilet training period. Of course there is more fighting and more force usually in certain families so by the time the child completes the anal phase he is in no condition to love the object that he ordinarily would love. His destructive and cruel tendencies are uppermost and one

would say he is not too promising a candidate for a healthy solution of his oedipal situation

To go back to the preschool group We were able to teach the mothers of this group that the occasional night terrors, temper tantrums or wet beds were sometimes a 'welcome outlet for the small child although painful and unpleasant to the environment.' Also, the so-called bad habits, e.g., nail biting nose picking, and masturbation may cause a good deal of anxiety to the mothers The child enjoys himself and it is that aspect which aggravates the mother When taking histories from our Wellesley mothers who are more sophisticated than most, we found that they were loathe to complain about such unpleasant happenings for they had learned to expect them

We had to emphasize that the school age child with such habits in the foreground needed psychiatric help The mothers of the six to eight year old children complain unanimously about the annoying tendency of the child to have explosive outbursts Poor handling of such outbursts, e.g., by punitive counteraggression on the part of the parent or teacher, or by cold withdrawal reinforces and amplifies the child's aggression If such a child is controlled rigidly at home, he becomes a disturbing element in the school Many class bullies fall into this group

Encouraged by the rewarding aspects of the educational work done with the preschool mothers and kindergarten teachers in handling tantrums we studied the six to eight year-old group with the parents and teachers who suffered from these children's aggressiveness The result was that the parents and teachers were taught to recognize when it was wise to release pressure and to find better outlets for the child's energies which would assist the socializing process rather than retard it

If the aggressive, destructive behavior of the child did not clear up with this type of manipulation he was studied more closely by the psychiatrist in the Project. Often the explosive behavior was so marked that it indicated that the child was in the beginning stage of an obsessional neurosis Such a neurosis if untreated would solidify with the rigid defense mechanisms in the second half of latency, and cripple the child

The early histories of such children were similar in many ways to those described by Anna Freud (1943, 1944) in her Hampstead Nursery reports She showed that many young children had certain types of obsessional behavior with rituals of eating, washing, and dressing along with bedtime ceremonials The interruption of these rituals when the child became a resident of the nursery caused severe anxiety

The anxiety is easily discernible in such children if the rituals are disturbed before the obsessional neurosis consolidates We found a certain number of anxious children in the kindergarten and in the early latency

group. Their early histories also were similar to those of the children described by Anna Freud.

The entrance into school may provoke anxiety. An anxious child is unable to convey the cause of his anxiety to his parents. He tries by symptom formation to deal with it himself. Hence, behind the obsessive act or somatic symptoms hides anxiety. If education is able to bring about an understanding of such situations and their gravity for the future mental health of the child, preventive psychiatry has been utilized with profit. Many such cases were turned up accidentally in the Wellesley study and referred to the project for treatment. It is more difficult to treat advanced cases of obsessional neurosis or somatic disorders which have become entrenched in the personality.

However, a certain number of obsessive perfectionistic children are rewarded by the parents and the school teachers because they do their school tasks so well. It is not until they become slowed down and never finish their work that the neurosis becomes evident.

Another neurotic solution with far reaching implications was found in a large number of early latency boys who were referred to us because they presented 'learning problems' although they were highly intelligent. These boys showed, in addition, markedly passive feminine behavior. This disorder is invariably overlooked unless accompanied by other deviant behavior for such boys are often pliable and socially adroit. The sexual passive feminine behavior, if not treated, will have very far reaching, and serious consequences in adult life.

Before I joined the Wellesley project the emphasis of study was largely on the preschool group. In looking over the data compiled by these studies, one notices that this was energy well expended. The parents and teachers in this community are probably above the average in their concern for the children. The majority of the parents were young and healthy. The majority of their children were wanted and cherished. But, there were some couples who stood out even in this small community as people who would eventually have trouble with their children. For example, certain parents were classified by our psychiatric social worker as 'chronic worriers.' They never missed a PTA meeting. They were prone to anxiety. They needed a good deal of reassurance about their own behavior in relation to their children. Closer inspection often revealed an overpowering hostility below this mask of co-operation. Much of the hostility could be lifted once the parents understood that their children were showing reactions well within the normal range. In other words, the parents were almost like resonators when they were exposed to the raw instinctual behavior belonging to certain stages of childhood. They magnified its significance and reinforced its aggressive elements. They

were then unable to follow what they understood intellectually as the best way to handle the day-by-day behavior deviations. They wanted someone else to take the responsibility and to guide them. Their aggressive reactions appeared as a consequence of old, unsolved difficulties within themselves. These parents were young and plastic enough to take advice, and they benefited by discussing their problems, thus opening the way for constructive guidance in the Project.

The second group that stood out were mothers who could give a clear developmental history. They were well read, and able to quote the latest types of child rearing techniques, but that was as far as their understanding of the child went. They seemed to go through the motions of doing the right thing, providing toys, books and other outlets for the children, but when one tried to get a picture of the interplay between mother and child from the emotional standpoint, there was nothing but factual accounts of the child's progress without any affect. (Extreme examples of such mothers as described by Mrs. Rank, and Dr. Putnam at the Children's Center were not found in our study.) After a little pressing one might find a faint glimmer of hostility verbalized, e.g., the mother would say that she had "no idea that the child would be such a burden, and use up so much free time." This type of mother a few years ago might not have come into such close contact with her children. Financially well off, she would turn her child over to a good nurse maid. The child in this situation then was allowed a warmth that cultivated emotional responses. The fathers in these families were often successful men who provided plenty of money, but occupied a remote position in the home. We were especially interested in tagging children from these homes. Their counterparts were found from similar homes in our latency group study of which I will speak below.

The third group of mothers presented a familiar picture of what we called "symbiosis." Margaret Mahler has also used this term. Mother and child could not be separated being reciprocally dependent on each other. These mothers had strenuously resisted any attempt on the part of the child to become independent. The early histories of such children were spotted with transient eating disturbances, tantrums, defiant behavior, etc. But each disturbance was quickly dealt with and overcome by counterpressure on the mother's part, and the mother rationalized that she was able to overcome all the difficulties by her good "training." Outwardly many of these children behaved well but on closer inspection one noted their passive stubborn resistance. A few children from this group developed in addition severe somatic symptoms which were so unpleasant that the mothers had to seek help. Among this group of children were several four to five year-olds who had severe bowel disturb-

ances Children so overwhelmed will be apt to show pathology when they enter school Either they will refuse to go to school, or they will show extreme apathy and inability to get along with their peer group If they stay in school they become masochistic targets for the aggressive members of their group Furthermore, they may withdraw more and more and become noticeable for that reason Some may avoid emotional relationships and concentrate on high intellectual achievements This is a poor foundation for future mental health But by tagging such children and following them through latency, we hope to have the opportunity to check our constructs and to do preventive work.

I would like to concentrate next on the latency children (ages six to twelve), and to correlate our knowledge of the dynamic structure of this age with our findings at Wellesley

This six to twelve age group is one which most psychiatrists avoid Therapists feel uneasy with such children, and are often unable to make contact with them because these children seem to be, as someone has said 'little monsters' I have analyzed children of this age for many years Anna Freud, Berta Bornstein, Edith Buxbaum, Mary Hawkins Fritz Redl and several of the Boston group of child analysts have also worked with this age group

But before we take up our findings I would like to run over quickly what is characteristic of the child in the latency period In considering the forces, both inner and outer which are at work during early childhood, one is struck by the fact that the adults in the outside world are able to threaten punishment or loss of love when the child indulges in forbidden sexual wishes or actions Anna Freud says "With the shattering of the oedipus complex, the superego is established, and the impression of the parents with their prohibitions, and admonishments remains in the inner world of the child" At the beginning of latency, age six, the child is ready for school He now moves away from his home base but he carries with him in his inner world 'the rudimentary structure of the superego which will act as his conscience His feelings of guilt and self criticism will become manifest when he fails to live up to his superego requirements' On the other side, 'the pressure from the instinctual forces is still felt,' and so the years from six to eight are rather difficult for the child because he is changing rapidly in favor of ego strength and independence from his parents Sexual drives are actually not evident to the degree that they were in the early years It is the age of ego superiority, and the reality principle is being established Adaptation to the outside world is the task of the next few years If the child has entered the latency period with very poor solutions of his early struggles with his instinctual drives, we find a stormy period for the mother, the child, and

the teachers Anna Freud noticed that the "latency period is usually in existence for one or two years before the tendencies of the first infantile period fade into the background" Berta Bornstein (1951) in a recent paper has divided latency into two phases—the first phase covering this part of the development which she classified as the period of internalizing of the superego, the second phase, from nine to twelve, the consolidation of the ego and its defense mechanisms

Anna Freud (1946) also noted that, on the average, "the opinion is generally held that children are more neurotic in the latency period than they were previously" She differs with this idea and points out that "the latency period marks a definite decrease in the infantile neurosis because the strength of the infantile wishes really die down partly for biological reasons, and partly because of the frustration of the oedipal wishes of the child" She goes on to say that "this lessens the need for defense against the instincts and alters the compromise formation between the Id and the Ego which really lie at the root of symptom formation Therefore, many infantile neuroses disappear at this stage" Their spontaneous cure is due to these changes If, though, "the pull of instinctual wishes is too strong, the principle which governs the child's life remains to a large extent the pleasure principle" I think that the children who have been referred to the Project either from school or from home, in the latency period, were children who have not been able to make these steps which are required for a healthy development

There was a predominant number of boys referred from public schools because of poor adjustment with their peer group or because of aggressive behavior, defiance of authority figures, etc. There was also a group who presented marked "learning difficulties," i.e., faulty sublimation with certain regressive infantile behavior patterns, as well as dependent tendencies, and a passive feminine behavior

The girls in this same age group were for the most part, referred directly from the homes because of difficulties with their mothers A few girls were referred by physicians because of hysterical symptoms In each case, when we were able to study the developmental histories, to interview their parents, and to assay the elements of the home situation, as well as gauge their school performance, we had a much better picture of what was going on than we ever could get from ordinary psychiatric interviews alone We did not get a one-sided view of the child We were able to study these children from all angles at the time of referral The histories showed us points of deviation which had begun in the preschool period This information has greatly helped us in sharpening our tools for observation as we work with the current preschool group, and the family constellations in which they live

Limitations of space permit me only to focus on the group who showed "learning difficulties," who came to the Project for psychiatric study and psychotherapy through school referrals. These children were highly intelligent, but they were unable to do their work in school, even with tutoring. Many of these children showed faulty sublimation. For example, certain subjects became taboo because of their unconscious meaning. Through utilization of the mechanism of displacement sexualization of certain areas in the learning field had occurred, blocking specific mental functions, so that memory and attention were interfered with. Curiosity, which should have been available for learning, was anchored and bound to the original traumatic situations or forbidden subjects. In this group the boys were in the majority, and all showed passive feminine attitudes. A few of the girls were noticeably aggressive.

Through psychiatric help, these children's unhealthy patterns were broken up and new outlets were found for the energy thus freed. Factual information was substituted for superstitious and/or forbidden ideas which controlled their thinking. The teachers were of great assistance to us. They worked along with us as we showed the parents how to alter pressures which were aggravating the situation. Teachers were able to substitute a system of rewards which made the child willing to try to utilize his potentialities instead of fighting silently with his head down and getting pleasure in being a deviant, which was all he could do without help.

Another group of children who often pass unnoticed in the school were those who showed good intelligence and had no trouble with memory, and no sexualization of the learning field. They received rewards for their intellectual achievements both at home and in school. When observed more closely one perceived that they were often cold and without affect. They took refuge in scholastic achievement and were unable to adjust to their contemporaries. Such a solution was far from an ideal one, because in later life they often tend to become withdrawn, isolated and lonely. All these tendencies had shown up in the earlier years but nothing was severe enough to bring the child to a clinic.

When we studied the parents of this group of children we noted that the way one or the other parent handled his difficulties was the method of choice of the child. The child did this through the mechanism of identification. It was possible during therapy to provide new identification objects for the child in the form of the therapist and teacher who worked with the child. As Dr. Edward Bibring has often pointed out, by clarification of the situation one could achieve through re-education a better solution of what might become a fixed neurotic response. We certainly could not change the parents, only the child's adjustment to

them By reopening channels of communication and mutual understanding between the child and his parents and his teachers, we were able to bring together and consolidate all efforts which in turn brought about a better realignment of inner and outer forces Crippling pressures on the developing personality can be altered if one has access to the proper environmental support as well as skilled psychiatric help When poor solutions are laid bare in the treatment situation, the co-operation of the home and the school help the child to utilize the new energy thus made available for many channels of sublimation which had previously been blocked

The aggressive children presented an added difficulty in the school because of their disturbing impact on the group Destructive and cruel, they often were able to swing the whole group to torment one member This victim, rather than fight back, would take the pounding of the group Eventually such victims developed neurotic responses such as psychosomatic symptoms, e g , vague pains and aches, nausea before school started, etc., or they learned to isolate themselves by withdrawing from group activities

The attitude of the teachers as well as that of the parents plays into this whole problem very much more than is usually understood For example, in working with the schools, one learns that the teachers often are indifferent to this group activity They say that this always happens in the second, third and fourth grades, but in the fifth grade the children 'settle down' Many teachers turn their backs on the activity of the group and feel that the children should settle their problems themselves We found that the children who had had difficulties earlier with their siblings were inclined to react in a similar way in the group The 'only' children were often without weapons or ability to know what to do when this group aggression was turned on them, and they sometimes suffered markedly from it They became depressed or disturbed and often wanted to stay home If the teacher identified himself with the cruel leader of the group and did nothing, there was no constructive help given One of our tasks has been to show the teachers the necessity of being alerted to group problems and of being clear as to the role they assume in relation to the group activities, that go on under their eyes Then they can correct problems that had not been dealt with at home e g , the whole problem of sibling rivalry which is played out again in the group One child will be targeted, hated and extruded by the group When this child is ready to collapse another child will be extruded in turn This goes on until every member of the group has come in for this sort of treatment In a group like this there is always a leader who is usually an unhappy, poorly adjusted child, unable to manage the problem of aggression If the teacher does not in

terfere, she gives permission for this sort of behavior in the group to the detriment of many members

Curiously enough the children who are victims of group aggression often show learning difficulties as well as characteristic disturbances at home. Usually they do not talk about the torments they experienced at school, but one or two extreme cases came to our attention because of night terrors or sleepwalking. Their school work always suffers. These objects of group aggression also showed hyperirritability. Some became extremely fresh and hateful to their parents in an attempt to unload the aggression which they had to take passively in the school. This behavior created another problem at home e.g. these children often received punishment when they should have received sympathy and constructive help. The psychotherapist by making a way open for a better solution does a real service for the child.

I would venture to say that in the socializing process that goes on in the school group many nascent neuroses flare up and various mechanisms are utilized by the children to keep away from dangerous areas.

A word about the intrafamilial group pressures which have shown up very clearly in our study. For example we have found that a certain number of parents have had mental illness and are frightened about its possible return. They are then on the lookout for deviations in the child's behavior. They often bring about unhealthy solutions because of pressures which they exert on the child. Certain parents in this group have been followed carefully in the Project and have had supportive therapy. They have been helped to find solutions for their tensions outside of the home in activities in the community. When the pressure on the children was removed there was a remarkable change for the better in the whole home.

I hope I have been able to show the vast and fascinating field that opens before our eyes. I hope you can see the value of constructive assistance at various age levels both for the family as a whole for the children for the schools and the community.

There is a difference in the work of the Wellesley Project as contrasted with that of the Therapeutic Child Guidance Clinic. The Staff of the Therapeutic Clinic works with the individual child, his family and perhaps with his teacher. In Wellesley we have an additional factor to help us that is the whole community. This community has been so educated that the home, school and all elements of the community co-operate at the same time. The child is not isolated with his problems but the community is ready and able to assist us in whatever way and whenever it is necessary.

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is actual exhibitionism, again with a reversed sign and with the aim of hiding something else hostile, stubborn—even vainglorious—tyranny. The data from our young patient bring into high relief the proposition that whenever a masochistic development achieves any significant proportion this camouflage is often unsuccessful, and that the concealed impulses are experienced by those on the receiving end as aggression proper or desperate demand. We shall see that this is clearly the case when in an acute decompensation the various ego functions which have buffered the infantile drives suffer a partial or total collapse.

Even without the further clarifying material of our case brought out during such a severe period of decompensation the highly condensed history so far brings confirmatory data for Reik's hypothesis. Allerton it will be recalled, was emotionally deprived and intensely demanding of attention from an early age, with periods of impervious stubbornness with regard to food or to the unalterable correctness of her opinions. Her characterological techniques for dealing with her deprivation and her rage took on one level the form of extreme self sacrifice and abdication of personal achievement, in the excesses of these, we see already an accusation of her parents. On another level, we see early her talent for presenting herself as the lovable clown, who extracted affectionate responses from people while hostilely unmasking her parents. On yet another level, her characteristic *projection* of her own needy and exploitive impulses is seen in her view of all her relationships as a situation in which she must 'give' limitlessly and/or be 'dropped' when her usefulness comes to an end. The eruption of the openly sadistic fantasy (of killing her mother) and of the victory in defeat fantasy of her own death—which brings everyone's love—testify to the weakness of all of these defensive and adaptive efforts. While Reik's focus on the importance of the sadistic fantasy and of disguised aggression in the development of the masochistic character is borne out in this case, it seems to me that his presentation largely omits the crucial importance of the *projective mechanisms* and in common with most other recent discussions of such complex formations as masochism does not allow for a clear conceptualization of the relevant phenomena in terms of a steadily shifting balance between drives and ego functions.

To put it more systematically those clinically observable phenomena which we usually subsume under the heading 'masochistic' do not appear to be simply direct instinctual expressions (Freud 1920) nor, as some have described them, only defense mechanisms (Bergler, 1949; Berliner, 1947). They are rather highly complex sets of configurations which issue from special varieties of infantile need and rage being pitted against a variety of mediating defense mechanisms and in interplay with the available

creative or adaptive ego functions, whether these be humor, aesthetic talent or whatever. Significant redistributions of psychic energy as in a decompensation and a rebuilding bring various aspects of this complex interplay into relief.

Although it does not yet seem possible to elaborate in systematic detail the precise nature of the underlying drives and defenses which are *specific* for the formation of those psychological phenomena commonly recognized as masochistic, it does seem possible to suggest a schematic outline of them.

First, on the side of the primitive drives. Reich (1933) suggests that an excessive, essentially unmeetable demand for love (plus an unusual disposition to anxiety) is the starting point for the consequent rage which develops when this demand is not met. The complex and infinitely toned varieties of masochistic formations express thus simultaneously the unusually strong need and the consequent aggression when this need is frustrated in fact or fantasy.

Second, on the side of the defensive functions of the ego, although the literature on masochism rarely discusses the problem in these terms, the clinical material offers a fair consensus that the triad of denial, reaction formation, and introjection is regularly present in the masochistic character. The form of defense rarely emphasized is that of the *projective mechanisms*. The available clinical data suggest that these have a singular importance for the masochistic formation.

We see first the projection of insatiable demands in the masochist's assumption that all people are as imperiously needy as he and he must therefore be inexhaustibly giving. In short, when he is functioning well he gives his objects what he would like to get from them. As the hostile component in his ambivalence mounts, this "giving" becomes an aggressive, smothering attempt to control—experienced by the object not as a gift but as an enslavement. We see also, however, his projection of hostile impulses and accordingly, the provocative gingerly testing approach to all human relations with the pervasive feeling that his chronic misfortunes and disappointments are the other person's fault. He is ready to feel exploited as a direct consequence of his projected exploitiveness. In a more complex fashion the projective mechanism in a masochistic formation may be used as the vehicle for what one might call a benevolent paranoid attitude, where the usual *denials* of, and *reaction formations* against, hostile impulses are projected wholesale and people are seen as essentially good and without malice, the Pollyannaism so familiar in the masochist.

One could multiply examples of the variegated forms which these four defensive processes may take including those special combinations which

taken together produce what is considered a normal "superego" function. I have discussed the projective mechanism in some detail not because it is more important than introjection, denial, or reaction formation but because these latter have frequently been identified in masochism and discussed on a clinical level, whereas projection has not been.¹⁰

In addition to the defensive processes, when the synthesizing or creative functions of the ego are functioning reasonably well, the masochistic character will be able to express and modulate his primitive drives via the many adaptive inventions of the ego. For Allerton, we have seen that one of the important configurations issuing from all of these opposing forces was the role of the good humored "teasee" or sly jester which she could be at her best. Her underlying demand for a response to her self-exhibition was partially met by making her audience laugh. In such "good" times, the denials and reaction formations set up against need and hate often held up well and we could observe generosity and self-sacrifice which stopped short of hostile, engulfing lavishness. Her aggressions were at the same time expressed and yet held within limits by her witty unmasking of others while seemingly caricaturing herself.

When, for some reason, the ability of the ego to maintain such an equilibrium is weakened, usually through a threatened or actual loss of love, there comes an impoverishment of defensive and adaptive-creative ego functions, and we see the disappearance of the crucial controls and modulations ordinarily provided by the defenses and the synthesizing functions of the ego; at such times the raw drive components of the total configuration "masochist teasee" emerge more sharply and it is much easier to see both the infantile need and the rage, which, though always present, are significantly altered when filtered through the medium of character traits or complex ego functions. The unleashing of the well known extortionist demands for love emerge, ranging from relentless self-deprecation to suicide attempts. If the decompensation progresses further, without a successful suicide, we see a progressively direct expression of the imperious infantile need for nurturance together with an undisguised rage or actual destructiveness. This more extreme development may also take the form of a psychotic depression. It is the

¹⁰ It is not clear whether genuine identification as against simple introjection is employed here also as a defense; Anna Freud (1936) in her discussion of the phenomenon of "altruistic surrender" presents projection and identification as the leading ego functions which both defend against, and make possible the gratification of instinctual needs in this form of "altruism." She adds in a footnote, "In any case it is certain that projection and identification are not the only means of acquiring an attitude which has every appearance of altruism, for instance, another and easy route to the same goal is by way of various forms of masochism" (p. 146), implying apparently that masochism stands distinct from the described form of altruism.

emotional blackmail which is most familiar to us in the hospitalized masochistic character who has decompensated

Allerton was on the verge of this phase when she came for treatment. Let us return now to her story—her acute collapse and reintegration—and see whether indeed it offers support for these formulations

It became evident early in her work with her first therapist that the beginning of Allerton's decompensation had been precipitated by her stormy relationship with Tom, an obviously paranoid youngster whom she had met at a school dance. She had met him around the time of Helena's graduation from the same boarding school she attended, and in the setting of her feeling that without Helena, she would surely perish. In spite of bitter opposition from her favorite teacher, Allerton clung tenaciously to Tom because it seemed clear to her that 'only somebody like Tom whom nobody would want, would want somebody like me'

She felt her teacher withdrawing her affection and in fact began to feel persecuted and hated by her, as well as by the other students. Now she turned to Tom's mother—a paranoid religious fanatic—as a substitute, and reports that, 'at least at the beginning, she treated me like I was her very own daughter'. Both Tom and his mother began a campaign of paranoid attack on Allerton's parents, weaving together the basic truth that she had never really been loved by her mother and father, with delusional convictions that they were having her shadowed by detectives and simultaneously taking active steps to ruin Tom's chances as an aspiring painter.

Allerton was much confused and profoundly disturbed by this frontal assault on her none too-secure defenses against her basic rage, but nevertheless managed to cope with the problem yet for a while. It was when her parents received a set of anonymous vituperative letters that they made the final decision to send Allerton to a sanitarium, with the main aim of separating her from Tom.

Inasmuch as the therapist could not accept the role of guardian against Tom, Allerton was given permission to see him for visits. Although she was by this time quite depressed and anxious, she was still able to attend school and take the role of court jester. The last straw came in the form of Tom's catastrophic failure in competing for an art scholarship—a failure for which his mother blamed Allerton. On the very day he was to take a competitive examination in sketching, he developed a psychogenic paralysis of his fingers and so did not appear for the examination. His mother immediately decided his many visits to Allerton had so exhausted and drained him that he had nothing left for his work, she began to bombard her with violently accusing letters accusing her of vicious greed, sexual immorality, and general worthlessness—adding that she would now ensure the termination of Allerton's relationship with Tom.

Allerton's reactions to this blow were complex indeed. Her difficulty in communicating with the therapist increased, along with her caricatures of deference and terror. She blurted out several times that Tom's mother was absolutely right in her accusations and finally, in an agony of shame and righteous self loathing

she confessed that on one occasion she had been sexually intimate with Tom at his insistence

Gradually, she began to give up her witty "acts" and embarked on a systematic program of withdrawal and intended self-destruction. At first, her moves in this direction were relatively mild. She ceased all activities she regarded as "fun" (going to movies or sports events), saying she did not deserve them. She began to skip her favorite classes at school, miss many meals and strip her room of her most cherished objects. She was insistent in her therapy hours that anything she might say would bore or anger her therapist so she had best remain silent. The demandingness of this silence was acutely felt by the therapist. Occasionally she would state dogmatically that she was becoming more and more certain that both the therapist and the chief nurse (whom she had adopted now as a benevolent mother figure) hated her, but that she was waiting for the inevitably forthcoming "final evidence" for this before she would kill herself.

Her growing paranoid attitudes were accentuated by the fact of her therapist's developing physical illness which resulted in an occasional cancellation of her appointment. She did not believe he was ill, but rather that he could not tolerate seeing her. Now her fierce determination to destroy herself gathered momentum. She began to miss most meals, to stand before an open window on freezing nights, and to invent complex techniques to avoid getting sleep: pacing in her room for hours, setting her alarm clock to waken her, leaving her light on, drinking much coffee, and finally swallowing a great number of dextrodine tablets she had secretly stored up when she had been on a reducing diet.

In the face of this behavior, her therapist had her temporarily transferred to a nearby hospital with closed facilities, telling her she could return to the open sanitarium when she was better able to control herself. Within twenty-four hours of her arrival at the closed hospital she was eating, sleeping, and pleading to return. This last item is of crucial importance in assessing the value to Allerton of her self-destructive behavior as a weapon to wrest love and attention from her therapist and the chief nurse—as against an interpretation of her behavior merely in superego terms or as sadism directed at her introjected parents or their surrogates. I believe it was in part a function of her concrete and essentially immature view of the world that enabled her to drop her self-destructive efforts when not in physical proximity with the objects of her emotional blackmail. We know it is by no means the rule that such maneuvers are foregone by this kind of patient when removed from the presence of the longed for, hated people in his life. Perhaps the fact that Allerton was an *adolescent* (without a history of malignant autism) contributed to her ability to change her major lines of strategy so abruptly. The "role diffusion," described by Erikson (1950), so ubiquitous in adolescents, makes them especially good candidates for the study of shifting redistributions of psychic energy.

She returned to our open sanitarium at the end of a week, having eaten and slept well consistently, but within the next two weeks began slowly to renew her campaign. This time, her program was interrupted by her therapist's having to undergo surgery and she was taken into treatment by the writer. Although this

event was unquestionably perceived by Allerton as a new abandonment and a new crime for which she was responsible. I do not believe her course would have been substantially altered without this added burden.

Now after a brief respite Allerton took up with renewed vigor and iron obstinacy all of her earlier self-destructive pursuits and more. In spite of relatively large doses of sedation she managed to sleep a maximum of four hours a night, often no more than two, consciously regarding this sleep battle as her most important fighting front. Whereas earlier she had maintained she did not deserve to sleep, now she regarded it as a piece of character weakness if she slept. Her avowed purpose was to bring about a fatal physical illness as a result of exhaustion, thus at long last bringing to fruition her long-rehearsed fantasy of winning boundless love from and stimulating infinite guilt in her family—and for that matter everyone who had ever mattered to her.

In spite of her conscious knowledge that I was doing everything I could to help her get some sleep, she could not escape the conviction that I was deeply disappointed in her and contemptuous if she did sleep for a few hours. She apologized daily for still being alive and repeated at the end of each appointment that it was her last 'promising' me that she would surely have the job done by the next day. While the projection in this of her own self-contempt and of her superego demands was clear, there was a bitter accusing irony in her grand-scale staging of the 'pardon me for living' message. She seemed to be saying, 'I am not taken in by your pretense of wanting to help me. I know you want me to die. I am doing my best to oblige, but you make my task harder with all these safeguards you provide.'

As it became evident that her astonishing physical hardness was blocking the development of any illness in spite of her lack of sleep, she began to turn to more direct methods. At first she began to mutilate her hands with pins, digging fiercely under the skin. As she became more ambitious with these techniques, turning to razor blades and glass, it became necessary to put on a twenty-four hour shift of special nurses with her. I still hoped at this time to see her through this acute period without again transferring her to a closed hospital.

In spite of these precautions she would manage ingeniously to get bold of a match or a still burning cigarette and dig it into her skin, burning herself on one occasion quite badly. She was immensely exhibitionistic in all of these activities and took an open, fierce delight in them—often baring her teeth in a biting grimace as she tore at herself or banged her head against the wall.

Occasionally even in the midst of these stormy nine weeks there would appear a burst of effort to restore her previous modes of functioning. Once she pleaded with me that I hire her as my maid; she would give me 'excellent service' and not even ask to see me. It would be enough just to wash my floors and do my laundry. It was clear from her associations that the fantasy was to become my Cinderella daughter, a role familiar to us from the history of her relationship to her mother and sister. On another occasion she bought a goldfish and named it after her previous therapist, thus drily turning the tables with regard to who was scrutinizing and controlling whom.

These small and desperate bursts were without real substance, and the general trend of her behavior became more openly demanding, destructive and actively suicidal. She tore up all the pictures of her family except that of Helena, confiding however that she was reserving Helena's picture for a special purpose—to smash it over her own head and use the glass to slash her wrists. It is curious how the outlines of sardonic accusation remain even in this violent extreme.

There could be little doubt that she had now selected me as the outer object of all of these activities. While on the one hand she would tell her nurses repeatedly that she *had* to find some way of pleasing me, she would unfailingly announce on the way to my office while inflicting a new self-mutilation: *I have to hurt myself before my appointments and no one can stop me!* There was nothing frightened, mute or cowering in her manner at such times; she was a tough, articulate and fearless warrior.

At the peak of her desperation she became openly paranoid, deciding for example that some hoax was being 'put over' on her and that the sedation was a special form of torture devised by the chief nurse. She determined now to get in touch with Tom—not because I want him—I just want his love. When he did not reply to her letter she concluded he was dead and that she had done it. It was at this time that her outbursts could no longer be managed even by her three nurses. She would dash quickly in front of a car or run toward the river if taken for a walk. The exhausted nurses gave up at this point and the decision was made that she be transferred again to closed facilities. I assured her I would continue to be responsible for her and to see her through her crisis.

Again within a very short time her dramatic symptoms ceased—and she was pleading to come back. After long debate it was felt that the best therapeutic strategy at this point would be to support her ego controls by maintaining a minimum geographic separation outside of a hospital if possible. However, I kept in close touch with Allerton and went to see her while she was still at the closed hospital. She was able to discuss with some insight what had happened and her behavior continued to be exemplary.

At the end of several weeks I decided to enroll her in a private high school and to continue to treat her as an outpatient. The sequence of the rebuilding of her ego functioning was perhaps the most illuminating aspect of this case.

It is difficult to establish a precise chronological order for the return of Allerton's modes of defense and adaptation. It is my impression that her reaction formations against rage came back first. Whereas she had been openly hostile and fierce, often shouting during the period of her acute decompensation, she now became quiet, exaggeratedly ladylike and slowly rebuilt her caricature of apparent vulnerability in her facial expression and bodily movements.

Almost from the moment she enrolled at school, the principal began to tease her and to caricature her apparent awe of him. She was significantly depressed at this time and found his teasing hard to tolerate. She was as yet quite unable to meet it with an answering rage. Although she had dropped the paranoid ideas which had become so fond during her acute period, she continued to be "insecure" and suspicious, finding it quite easy to believe that the principal had

singled her out as a special target of his general scheme to make students as miserable as possible

Perhaps the best summary of her vacillating status at this time is a brief poem she wrote

Two hands
One living one dead—
Incapable of giving life or death
To each other

During her therapy sessions the most striking new shift in her psychological economy was the emergence into consciousness of her sadistic fantasies. One cannot be certain whether or not she had been conscious of these before her psychotic period. The most frequent fantasy was of murdering the lady with the shopping bag. It was usually stimulated by her seeing a woman carrying a bag of groceries reaching its highest urgency if there were a child with the woman. The rage against the withholding mother and rival sister seemed unmistakable here. Her other favorite fantasy was the mass slaughter of American soldiers; she literally wept over any Allied victory. This identification with the aggressor was linked by her to an early memory of a fantasy in which a robber comes to kill her parents; at the moment he is about to murder them she vigorously steps in, turns aside his hand, and is killed herself.

Her sadistic fantasies aroused immense anxiety in her and she found it hard to tell about them, but they kept coming. One is reminded here of Reik's formulation regarding the development of the masochistic character: that the sadistic fantasy is the detour taken when the primitive aggression or need has been diverted from its original aim (1941). He points out that just as the sadistic fantasy is the fostering soil of masochism, genetically so must it be passed through on the way back in therapy.

Allerton's depressed mood continued with occasional abortive efforts to harm herself by not sleeping or by accidentally injuring herself bodily. These remained quite limited, however. As we continued to analyze the nature of her relationships with other people, she began to experiment once again with attempts at setting up intimacy, first with a girl her own age and then with a boy in her class. Predictably enough, Alex, though a warm personable youngster, was known to be the star teaser of the school. The following incident, told by Allerton, sums up her adjustive efforts early in this relationship.

We were looking at an old yearbook of mine. Alex came along and I tried to hide the book so he wouldn't see my picture. I looked so awful. He took it from me, looked at it and said, "My, but you were a fat blob last year. That was too much. Alex is a terrible tease, but with me, most especially. Usually I try to be a good sport, but this really got me." I rushed off and wrote a long letter to him describing in detail how ugly I not only was last year but am now, what a beastly personality I have and too bad he hadn't found me out sooner. It hurt him terribly—I never saw anybody so devastated.

This last was said with such evident satisfaction that I remarked, "An expert job of hara kiri?"

Allerton was delighted with this idea and, for a moment losing distance completely, burst out with 'how nice it would be to commit bara kiri on Heleoa's doorstep' When I then interposed, 'So you have some revengeful feelings toward Helena after all', she quickly denied this and said she had been joking. It took a long while yet before Allerton could genuinely accept her vindictive retaliatory impulses toward her family. She had repressed most of the events of her agitated period.

Gradually, to her immense relief, her sadistic fantasies appeared less and less often and her depression began to lift. As she came to understand her provocativeness and roundabout aggressiveness she was able to consolidate her relationship with Alex, retaining to be sure the essential features of the 'teasee,' but with sufficient modulation that her humor more often became witty banter instead of self deriding exposure. There can be little question that a secret mocking of authority remained an important ingredient of this humor. She wrote the following for the school newspaper.

AN ANECDOTE

Miss Speer, the head mistress led the procession of sloppy girls into the bare gymnasium as I played the processional. It was now time for morning chapel which consisted of a lecture that bothered one's conscience slightly and left one cold. But I was the obliging fool who played hymns, processions and recessionals whenever Miss Speer signalled me with that fateful nod. I had always been conscientious at this job but it was now one of those blue Mondays when there was a decided need of excitement.

I leave you with this thought: always do a little more than just what is expected of you.

Those were the last words of the morning talk, so Miss Speer nodded reverently and automatically for the recessional. I smiled nervously and began my revolutionary rendition of the Wang Wang Blues.

As Allerton continued to restore herself and to mature, she again found herself doing many favors for people and finding it difficult to say 'no'. Although she began to experience conscious anger more often than before, her need to deny this frequently issued in mild depressions. Her ability to make open demands increased along with a more direct expression of what she now began to call her 'bossiness.' While she dropped her rigid formula that 'people are out to use you and then drop you' she retained an essentially testing attitude toward all human relationships, smarting readily under criticism and maintaining highly sensitive antennae for rejection. Perhaps the most marked change occurred in her social role. She found herself being teased less often, although her role as humorist was maintained. In addition her earlier ambition to become a nurse disappeared and she became instead a violin instructor.

In short, although the redistributions of psychic energy have been sufficient

to effect a significant difference in her internal experience and certainly in her social effectiveness, the unique gestalt which has for a long time been Allerton W retains a certain constancy of configuration. Perhaps this persistence of essential pattern is a function of the necessarily limited nature of the modified psychoanalytic technique used with this adolescent. I do not think so. We will have no answer to this problem until systematic investigations are made of the premorbid development of patients who then undergo a long term, thorough character analysis, and whose lives are followed after its successful termination.

Obviously, such a sketch as I have offered, written with one eye on an hypothesis, must necessarily do violence to the complexity and subtlety of the development of a human being. I have abstracted those aspects of the case which are most pertinent to our problem. My actual experience with this patient, if not my highly condensed report of it, has convinced me, first, that it is possible while recognizing its quasi stability to dissect conceptually even so complex a configuration as "masochism" into its component vectors, particularly when a pathological process provides a kind of "sorting" of functions, and second, that the specific set of attitudes which constitute being a "teasee" or a court jester can be most economically understood as an aspect of the development of *one type* of "masochistic character." I mean by this label to designate a pattern of human development which is not simply a direct instinctual expression, nor merely a defense mechanism, but a highly organized, hierarchically stratified set of functions designed simultaneously to express aggression, however circuitously, and to obtain gratification of infantile needs in fact or fantasy, however long delayed. The circuitousness and the delay are mediated by a complex organization of defensive and synthetic ego functions. The specificity of "moral masochism" may lie not only in the excessive infantile need for love with the attendant predisposition to anxiety and rage, but also in the choice of mechanisms of defense: introjection, denial, reaction formation, and projection. While the socially adaptive ego function of humor takes the special form of calculated self derision or buffoonery in the "moral masochist," I do not believe it is an indispensable attribute of this character development. We know many who are humorless, martyred "saints" who do not joke and who are never teased. Perhaps there are no specific forms of *adaptive* ego function (if indeed one can separate these sharply from *defensive* functions) which are peculiar to a masochistic character formation.

III. FURTHER THEORETICAL CONSIDERATIONS

The theoretical aspects of this presentation are divided into two groups: first, those concerning the general assumptions underlying the

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III FURTHER THEORETICAL CONSIDERATIONS

The theoretical aspects of this presentation are divided into two groups: first, those concerning the general assumptions underlying the

attempt to systematize complex configurations of psychological functioning, roughly outlined in a previous paper, written in collaboration with Gill and Knight (1952), and second, the theoretical problems posed by one such configuration, chosen as illustration, namely, that of the "masochist teasee."

With regard to the first, the premises throughout derive their foundation largely from the work of Hartmann (1939, 1951) and Rapaport (1951 a and b). The concept of the "motivational hierarchy," suggested by the latter, involving a complex stratification of motivations—which may operate variously as "mobile" or as "bound" cathexes—may serve as the starting point for the analysis of *any* complex psychological phenomenon, whether an isolated character trait, a chronic affect, a "life style," an alteration in a "state of consciousness" (Brennan, Gill, Knight, 1952) or as in our illustration of the comic "teasee," a social role.

The psychological shifts indicated in the sketch of the early development of the patient, as well as in the course of her illness and recovery, have been conceptualized essentially in terms of Hartmann's discussions of various kinds of "equilibria" normal and pathological. The relative constancy of *pattern*—though by no means of *content*—throughout the described vicissitudes seems to illustrate the "secondary autonomy" discussed by Hartmann (1951) in relation to the evolution of behaviors which originally arose in the service of a defense against a drive. That such "secondary autonomy" is however, a *relative* autonomy is indicated by the fact that we see firmly established character traits and characteristic social roles all but obliterated under the impact of a significant diminution in the efficiency of total ego functioning.

It is my opinion that the apparently irreconcilable contradictions which abound in the literature on "moral masochism" issue from the vain effort to reduce a variety of highly organized, stratified clinical phenomena to being a function of one or another of the three psychic institutions: id, ego, or superego. This necessarily oversimplified "structuralism" has led some writers to consider masochism an instinct (de Monchy, 1950) or at least a "partial instinct" (Fenichel 1945); it has led others to conceive it as a defense mechanism (Bergler, 1949; Berliner, 1947; Reich, 1933) and still others to view it mainly as a superego expression (Dooley, 1941). The complexities of the clinical observations of masochistic phenomena and of other phenomena of the same order of complexity are not to be encompassed by any one of these structural concepts. This general position stands very close to the propositions offered by Waelder in 1936 in his highly important paper on "the prin-

ciple of multiple function " There, he called psychoanalysis "a kind of polyphonic theory of the psychic life "

One is faced, then, with the alternatives of essentially abandoning the attempt to systematize the interpenetrations of function, or of making a start at such a systematization Reik (1941), in his clinically brilliant presentation of the phenomena of masochism, has chosen the first course, eschewing by and large what he calls the "jargon" of psychoanalytic theory When he sums up his hypothesis in the three words, "victory through defeat," he is presenting on a clinical level the subtle interplay of the primitive drives, the defenses against them, and the infinite variety of adaptive ego functions designed to mediate between the needs of the person and the demands of the external world

There can be little doubt that Freud's abandonment of his initial belief in masochism as a secondary formation, and not a primary instinct has brought, as Fenichel (1935) puts it, 'more confusion than progress ' Some writers have attempted to side step the blind alley of death instinct theory by the *tour de force* of setting up the dichotomy of "psychological" versus "biological" factors, maintaining that clinical observation can neither refute nor confirm this theory (Reik, 1941), others have avoided the problem by proposing a distinction between the "genetic" and the "clinical" aspects of masochism (Bergler, 1949) Although the fruits of the frontal attack made on the theory of the death instinct by Reich (1933) and by Fenichel (1935) have been seen in its progressive decline in clinical discussions, it persists as a source of obfuscation in many theoretical discussions of the problem of masochism, in so far as the premise of masochism as an id function is maintained

An example of this, in my opinion, is contained in an important paper by Bak (1946) wherein he discusses paranoia as "delusional masochism " He presents a series of steps in which he describes the regression from sublimated homosexuality to masochism as an essential feature of the *paranoid reaction* His careful clinical observations include the intrinsic connection between paranoid and masochistic formations, described also in our adolescent girl However, taking as a premise that masochism is an id function, he is forced to a formulation in which the layered defensive processes are seen as mechanisms designed to deal with 'the masochistic threat coming from the id " Accordingly, the presence of masochistic configurations in a paranoid reaction are understood as "a return of the repressed, and paranoia is delusional masochism "

If, on the other hand, one abandons the assumption that masochism is an instinct, it permits the formulation suggested earlier in this paper, namely, that in masochistic formations projective mechanisms play a

central role, particularly with regard to the need to defend against hostile impulses.¹¹

IV. SUMMARY

The general proposition has been suggested that advancing psychoanalytic theory, particularly ego psychology, now makes possible the attempt to break down into its components various complex psychological functions often regarded as simple, unitary expressions of one or another of the three psychic institutions: id, ego, and superego.

As an example of such an attempted analysis, the role of "comic teasee" has been discussed as one possible development in a masochistic character. This role is seen as a characterological expression of a masochistic development, the latter being conceived of *also* as a complex configuration specifically designed not to encompass primarily an unconscious need for punishment, but to maintain a balance between primitive libidinal and aggressive drives and at least four specific mechanisms of defense: introjection, denial, reaction formation, and projection. In addition specific ego adaptive functions also play a decisive role. I have tried to show that one or another of these components may come to the fore clinically, depending on the existing efficiency of ego functioning at the time.

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¹¹ In this connection, Hartmann (in a personal communication) raises the centrally important, little explored problem of why it is that certain individuals in particular conflict situations choose one mechanism of defense in preference to another. He says, "genetically, part of it might become traceable by studying the precursors of defense, on a developmental level predating the formation of the ego as a system in its own right. One aspect I tried to account for in pointing to primary autonomy, but there are other aspects We have also to ask which are, in a given person or a given situation, the relations between id tendencies and the development or the use of a certain defense mechanism" Waelder's (1936) excellent discussion of this issue is germane here.

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ON CHILD PSYCHOSIS AND SCHIZOPHRENIA¹

Autistic and Symbiotic Infantile Psychoses

By MARGARET SCHOENBERGER MAHLER, M D (New York)²

It seems that psychosis is the sad prerogative of the human species. It is not confined to adults alone. Animals are born with well-developed instincts which guarantee their independent individual survival soon after birth. In the human young, however, these animal instincts (in terms of sense of track) have atrophied and become unreliable and, as Freud stated, the ego had to take over the role of adaptation to reality which the id neglects. The somatic corollary of ego development is the central nervous system which is in a very immature state at birth. The neonate appears to be an almost purely biological organism with instinctual responses to stimuli not on a cortical but essentially on a reflex and thalamic level. There exist only somatic defense mechanisms, which consist of overflow and discharge reactions, whereby cortical inhibition is undeveloped. Thus, we may say, that at birth there exists only a rudimentary ego, incapable of retaining stimuli in any degree of tension, or else, that prevalence of the undifferentiated phase of personality development persists for a comparatively long period of extrauterine existence (Hartmann, Kris, Loewenstein, 1947). Yet the psychobiological rapport between the nursing mother and the baby complements the infant's undifferentiated ego. This normal empathy on the part of the mother is the human substitute for the instinct on which the animal can rely for survival. In a quasi-closed system or unit, the mother executes vitally important ministrations without which the human young would be unable to survive. The intrauterine, parasite-host relationship within the mother organism (Deutsch, 1945) must be replaced in the postnatal period by the infant's being enveloped, as it were, in the extrauterine matrix of the mother's nursing care, a kind of *social symbiosis*.

The young infant is readily thrown into affectomotor storm-rage reactions which, if not relieved by the mother's ministrations, may result in

¹ This is a revised version of a paper given at the 17th International Psychoanalytical Congress August 6, 1952 in Amsterdam, Holland.

² From the Children's Service of the New York State Psychiatric Institute and Columbia University, New York.

a state of organismic distress. This organismic distress is phenomenologically quite similar to the panic reactions of later life. As a second stage of his homeostatic insufficiency, the young infant may exhaust his life energy and may lapse into a kind of semistupor, reminiscent of his fetal existence (Ribble, 1941). The newborn and young infant gradually must be brought out of this tendency toward vegetative splanchnic regression, out of the tendency to lapse into this exhausted semistuporous state, into an increased sensory awareness of, and contact with, his environment (Greenacre, 1946, Spitz, 1947). In terms of energy or libidinal cathexis this means that a progressive displacement of energy quantities from the inside of the body (particularly from the abdominal organs toward the periphery of the body) has to occur so that the perceptual conscious system, as Freud calls the surface of the body, the peripheral rind of the ego, containing the sense organs, may receive cathexis. The turning from predominantly proprioceptive awareness to increased sensory awareness of the outer world occurs through the medium of affective rapport with the mother. The baby's libido position thus proceeds from the stage of fetal narcissism to primary body narcissism, a stage in which representation of the mother's body plays a large part. Thus, to repeat, the infant's rudimentary and very vulnerable homeostatic equipment after birth must be enveloped by the now extrauterine matrix of a mother's or a mother substitute's nursing care.

THE BODY EGO IN INFANTILE PSYCHOSIS

The core of ego development, the first orientation toward external reality, is the differentiation of the body image, which is the psychic representation of the bodily self (Schilder, 1938). Through the rhythmically recurring experience of painful accumulation of tension in the inside of his own body, followed by regularly repeated experiences of gratification, which the infant cannot provide for himself hallucinatorily beyond a certain point, the infant eventually becomes dimly aware of the fact that satisfaction is dependent on a source outside of his bodily self. Thus the infant recognizes an orbit beyond the boundaries of the self, that of external reality, represented by the mother. Bodily contact with the mother, that is fondling and cuddling, is an integral prerequisite for the demarcation of the body ego from the nonself within the stage of somatopsychic symbiosis of the mother-infant dual unity. Under normal circumstances infants do not only treat parts of the mother's body as if they were their own, but, as Anna Freud and Dorothy Burlingham (1944, p. 7) pointed out: "We assume on the basis of much evidence that the child's feeling of oneness with the mother's body has a parallel in the mother's feeling that the baby's body belongs to her." In terms of

libidinal and aggressive cathexis this implies that the baby's instinctual drives vicariously aim at the mother's body, particularly her eyes, mouth, band, face and breast, as if they were his own. He experiments with the feel of the mother's body, comparing it with the feel of his own. However, this learning about one's own body contour as separate from the mother's represents a relatively high degree of ego differentiation, an ability to neutralize and direct aggression, and a relatively advanced sensory perceptive awareness of the environment. Even this vague sensory discrimination represents a degree of development of the sense of reality—a stage which is by no means reached or maintained by all cases of infantile psychosis.

IN EARLY INFANTILE PSYCHOSIS GRAVE DISTORTION OF THE MOTHER-CHILD RELATIONSHIP SEEMS THE ESSENTIAL CAUSE FOR "EGO ALIENATION FROM REALITY"

Freud (1924) considered the ego's alienation from reality the pivotal disturbance in adults' or adolescents' psychoses. Ferenczi (1913) has described how the infant's sense of reality proceeds—through the stages of magic hallucinatory omnipotence—toward gestural and word magic—until, very gradually, he is able to accept and to master realistically his expanding external orbit. It seems obvious to those who have the opportunity to treat deeply disturbed children that the infantile ego's alienation from, or arrest of recognition of, reality is an occurrence inherent in the brittle and weak organization of the infantile personality (proclivity to ego fragmentation). To understand the dynamics in infantile psychosis observation and study of the most important transitory step in the adaptation to reality is necessary, namely, that step in the development of the sense of reality in which the mother is gradually left outside the omnipotent orbit of the self. This step is preliminary to, and perhaps alternates with, the process of endowing the mother with object libidinal cathexis. The toddler gradually delimits his own individual entity from the primal mother-infant symbiotic unit. He separates his own self (and his mental representation) from that of the mother. This stage in ego development is a very vulnerable one particularly in children in whose early life the somatopsychic symbiosis has been pathological (Compare Spitz, 1951).

THE IMPORTANCE OF CONSTITUTIONAL (INTRINSIC) FACTORS IN THE GENESIS OF INFANTILE PSYCHOSIS

In regard to the question of heredity versus early frustrational and traumatic etiology of infantile psychosis, we may say that it is very diffi-

cult to ascertain whether the grave disturbance in a case of early infantile psychosis has been caused by the mother's pathology and lack of empathy, or by the infant's great innate ego deviation, be it an inherent lack of contact with his living environment, or an inordinate need for symbiotic parasitic fusion with the adult. It is a fact that time and again we see schizophrenic children whose mothers appear not to lack warmth, genuine love, or acceptance of the individual child, nor do they appear to be exceptionally possessive, infantilizing and restrictive.³ Human nature provides a mutuality between the infant and his mother by which, on the one hand, severe traumatization, chronic emotional starvation on part of the environment, seems to damage a constitutionally sound baby only if the baby is very young; on the other hand (as the famous Dennis experiment has shown and as everyday life experience demonstrates) the constitutionally sound baby, beyond the fourth, fifth and sixth month automatically coerces the adult's empathy (Greenacre, 1944). The infant's contact seeking gestures appeal to woman's most basic biological longing. Hence emotional gratification as well as food are readily given unless maternal psychopathology has rendered the adult partner unable to respond. In other words, it seems that such basic damage to the ego which results in infantile psychosis, occurs in children who have a hereditary or constitutional "Anlage" for it, or in whom an intrinsic factor is prevalent. There are infants with an inherently defective tension regulating apparatus which probably cannot be adequately complemented by either the most quantitatively or qualitatively efficient mothering. It seems that there are infants with an inherent ego deficiency which from the very beginning—that is to say, from the stage of the undifferentiated phase—predisposes them to remain or become alienated from reality, there are others whose precarious reality adherence depends on delusional symbiotic fusion with the mother image.

AUTISTIC INFANTILE PSYCHOSIS

From the points of view of object relationship and development of the sense of reality, we may describe two clinically and dynamically distinct groups of early child psychosis. In one group of early child psychosis the mother as representative of the outside world, never seems to have been perceived emotionally by the infant, and the first representation of outer reality, the mother as a person as a separate entity, seems not to be cathected. The mother remains a part object, seemingly devoid of specific cathexis and not distinguished from inanimate objects. This

³ Compare Anna Maenchen (1951) who did not find unequivocal types of mothers pertaining to the severely disturbed children's cases about whom she reported.

type of infantile psychosis was first described by Kanner (1942, 1944, 1949) and given the name of "Early Infantile Autism." In autistic infantile psychosis there are no signs of affective awareness of other human beings. Behavior which would point to affective perception of ministrations coming from the mother—from the outside world—is absent. In the anamnesis of these children one finds descriptions of the earliest behavior, which betray that there was no anticipatory posture at nursing, no reaching-out gestures, and no specific smiling response. One finds the following data: "I never could reach my baby."—"He never smiled at me."—"The minute she could walk, she ran away from me."—"It hurt me so when I saw other babies glad to be in their mother's arms, my boy always tried to creep away from my lap as soon as he could."—"He never greeted me when I entered, he never cried, he never even noticed when I left the room."—"She never was a cuddly baby, she never liked caresses, she did not want anybody to embrace or to kiss her."—"She never made any personal appeal for help at any time."—This last remark of a very observant mother of one of these autistic children described the disturbance as seen in terms of social behavior.

Let me give you the example of my little patient LOTTA, aged three years and four months, who suffered from an *inherent* autistic disturbance. She provoked multiple traumatizations by a mother who herself lived in a hateful dependency on her own mother. There were severe feeding deprivations, a lip injury at spoon feeding occurred at a very early age. There was a strict and unloving regime of precocious toilet training. A vulvovaginitis followed the first signs of Lotta's beginning to "touch herself." Thus, traumatic overstimulation crowded out normal zonal libidinalization in all areas of psychosexual development. Yet these traumatizations, I believe, could not have occurred, if there had not been great intrinsic ego pathology. Daily struggles over constipation, with digital removal of the feces, was just one indication of the kind of atmosphere which prevailed. At the age of three and a half Lotta had no language, no gestural communication, no hand, mouth and eye integration (Hoffer, 1949). She neither fed nor handled herself and she showed a terrified startle reaction at any chance touch of or by another person. By the usual intelligence rating she would have ranked among the lower imbeciles. However, Lotta's habits were compulsively neat, her motor and manipulative skills were age adequate, her knowledge of, her memory for, her static inanimate environment were phenomenal.

During therapy, by using every conceivable device, she was slowly brought to sensory perception of the outer world, by gradually accepting contact with the analyst's body. Yet no normal identification occurred but instead there was extensive mirroring and parrot-like word formation. Word formation was autistic and speech was not used for intercommunication, but only for commands and signals—and it was used toward objects as freely as toward the analyst.

She seemed to catch up rapidly with isolated fragments of her arrested ego development. She went through repetitious aggressive exploration of her inanimate environment—banging the doors, switching the lights on and off, and fingering everything like blind people do.

There were bizarre discrepancies of body ego integration as the disconnected fragments of her personality forged ahead at fantastically uneven rates. Let me give you an illustration.

At the stage of treatment when Lotta went through repetitious testing of her environment, she would indeed tax the patience of her mother—a little flash light was provided for her by the analyst in order to drain away some of the disturbing behavior from the overstrained home situation. She became quite attached to the little flashlight. At the same time Lotta started to put everything she liked into her mouth. Thus she mouthed the little flashlight like a teething baby. When driving from the office that time her mother, as usual, used the automatic lighter to light her cigarette. Lotta unnoticed got hold of the glowing lighter and put it to her mouth, causing severe scorching of her lips.⁴ She showed practically no reaction. Her pain sensitivity seemed grossly below normal. This among other signs is, I believe, an indication of the lack or deficiency of peripheral cathexis in autistic child patients. In contrast, proprioceptive stimuli, visceral pain, was keenly felt and reacted to (Mahler, 1950).

To repeat, it seemed in Lotta's case at least unavoidable that autonomous ego functions emerged, were put together and existed simultaneously like a patchwork of loosely connected parts held together in a static way without the specific matrix of affective correlation in the course of treatment.

This bizarre picture of scattered ego functions and the clinically clearly discernible lack of peripheral cathexis make us realize that in autistic infantile psychosis the vicissitudes of libido and aggression can not be traced merely in terms of the hierarchy of zonal stages. Instead, we can in some cases trace during treatment the course of libido and aggression from the splanchnic visceral position through progressive cathexis in cranial direction outward onto the periphery of the body, the skin, and the sense organs, i.e., the perceptual conscious system (Mahler, 1950). The instinctual forces, both libido and aggression, exist in an unneutralized form, due to the absence of the synthetic function of the ego. There is an inherent lack of contact with the human environment.

Whenever Lotta was in great distress, her whole little body shook with tearless sobs; yet she neither sought nor accepted help from anyone but threw herself flat on the floor and pressed against the solid support of it. Likewise she would cling to the familiar high chair but not to father or mother. This autistic psychotic child was characterized (as were all those whom I observed) by a

⁴ Compare Hartmann, Kris and Loewenstein (1949).

peculiar inability to discriminate between living and inanimate objects, even in a perceptual sense (compare Sturnmann, 1947)

SYMBIOTIC INFANTILE PSYCHOSIS

There is, however, another group of infantile psychosis in which the early mother infant symbiotic relationship is marked, but does not progress to the stage of object libidinal cathexis of the mother. The mental representation of the mother remains, or is regressively fused with—that is to say, is not separated from the self. It participates in the delusion of omnipotence of the child patient.

Children of the symbiotic group rarely show conspicuously disturbed behavior in the first year of life, except perhaps, disturbances of sleep. They may be described by their mothers as crybabies or oversensitive infants. Their disturbance becomes apparent either gradually or fulminantly at such crossroads of personality development, at which maturational function of the ego would usually effect separation from the mother, and would enable the child to master an ever increasing segment of reality, independently of her. As soon as ego differentiation and psychosexual development confront the child and thus challenge him with a measure of separation from and independence of the mother, the illusion of the symbiotic omnipotence is threatened and severe panic reactions occur. These reactions usually manifest themselves in the third or fourth year, or else, at the height of the oedipal conflict. In other words it would seem that a break with reality is touched off by the maturational growth of motor coordination which harbors the inherent challenge of motor independence, or else, the complicated and differential emotional demands of the oedipal situation throw the symbiotic psychotic child into the described affective panic. In symbiotic child psychosis unneutralized libidinal and aggressive forces have remained narcissistically vested in fused systems of mother father child unit reminiscent of the primary unit (mother infant). Landmarks of fragmentation of the ego are traumatizations through sickness, separation (for instance placement in a nursery school), birth of a sibling but also all kinds of changes of a minor nature, which upset the precarious psychobiological balance of such children. Thereby the cumulative effect of previous traumata very often plays a role. The world is hostile and threatening, because it has to be met as a separate being. Separation anxiety overwhelms the brittle ego of the 'symbiotic psychotic child'. His anxiety reactions are so intense and so diffuse that they are reminiscent of the organismic distress of early infancy. Clinically, such children show all the signs of abysmal affective panic. These severe panic reactions are fol

lowed by restitutive productions which serve to maintain or restore the narcissistic fusion, the delusion of oneness with the mother and/or father. Restitution in symbiotic psychosis is attempted by somatic delusions and hallucinations of reunion with the narcissistically loved and hated omnipotent mother image, or sometimes by hallucinated fusion with a condensation of father-mother images. In the symbiotic infantile psychosis reality testing remains fixated at or regresses to the omnipotent delusional stage of the symbiotic mother-infant relationship. The boundaries of the self and the nonself are blurred. Even the mental representation of the body-self is unclearly demarcated. These are the cases, I believe, of whom Bender (1947) was thinking when she described their body contour melting in one's own. The autistic child's body, in contrast, is uniquely unyielding and feels like a lifeless object in one's arms (Rank and Macnaughton, 1950).

A peculiar hypercathexis of one part of the body is often encountered in symbiotic psychotic children. It seems to occur in those cases of symbiotic infantile psychosis in which parental psychopathology—the extrinsic factor in the genesis of the symbiotic psychosis—is rather prominent. In these, but by no means in all, symbiotic cases the adult partner very often seems to be able to accept the child only as long as it belongs as a quasi-vegetative being, an appendage to her or his body.

STEVE'S mother, for instance, had a good deal of insomnia during pregnancy due to her fears lest the baby be a boy, because her own brother had turned out so badly. Steve did not sleep enough to suit his mother. Whenever his eyes were open, she would hold him tightly in her arms for hours and would walk up and down with him until her arms were aching and numb and she could not feel her arms any more.

Is it a mere coincidence that Steve's most conspicuous symptom was going about compulsively asking everyone and also himself, "Are these my hands? Are those your hands? Can these hands kill? I am many people?" In his weird histrionics he compulsively enacted many characters all day long.

At four and a half years the child's extreme dependency—which his mother had previously enjoyed—so harassed her that she placed him in a boarding school, though he was still wholly dependent on her. At that time overt and continual masturbation seems to have been the last straw to break the camel's back as far as the mother was concerned.

In the case of one of my schizophrenic patients the mother was pictured by the child in analysis as a multi-pronged monster, a giant medusa or spider who would wind her fat legs around my body and squash me with all the manifestations of horror that only a schizophrenic patient can display. At the beginning of the treatment the mother lived in another country and thus had no contact with me. Later when she came for an interview with me, she sought my reassurance against her excessive guilt feeling because Babette's condition

might be due to the "terrible thing I did with her when she was a small baby." She went on to relate then that, since her husband frustrated her and treated her very badly she would compensate her sensual needs—as she put it—by taking the chubby, smooth little baby between her legs, and masturbating, rubbing the little body up and down her genitals.

A psychotic child's father, whose own legs were crippled (and whose death wishes toward the son were quite overt) related to the psychiatrist that he would sneak to the crib of the infant boy, night after night, and examine his legs in the fear to find something wrong with the baby son's legs. This schizophrenic child's main somatic delusions centered upon his legs.

It seems to me that these strange coincidences—this precise dovetailing of the somatic memory traces in these pathological delusional body sensations of the symbiotic child and the way in which the aggressive erotic appersonation was effected by the parent partner—cannot be without causal connection. The peculiar hypercathexis of one part of the body, which we encountered in many symbiotic children, often corresponds to the type of overstimulation which occurred during symbiotic relationships. This finding is noteworthy and deserves further careful investigation (Greenacre, 1944).

CONCERNING THE QUESTION OF "CHILD SCHIZOPHRENIA"

I now wish to take up a point implied by the title of this paper. I believe that all clinical evidence disproves the contention of certain psychiatrists and psychoanalysts, that schizophrenia does not occur before puberty, because the schizophrenic picture is based on the psychotic elaboration of the homosexual conflict. First of all, I believe that the main cause of proclivity for alienation of the ego from reality and fragmentation, is the above-described grave disturbance—a specific conflict of the mother-child relationship, be it autistic or symbiotic. Second, I believe—and have much clinical evidence to show—that bisexual conflict can be, and often is prominent in the symptomatology, the production, and even the immediate genetic cause of the psychotic breakdown of the ego in childhood.⁵ To establish the latter point, I would like to give two very condensed case reports.

⁵Dr. Greenacre in a personal communication originally designated as discussion remarks to this paper said the following: "In children suffering from severe and early traumata there is a condition of increased plasticity of the body responsiveness which may under certain conditions produce a severe bisexual identification. There are then bodily hallucinations of bisexual nature which persist and play an important part in the child's fantasy during the early latency period."

GEORGE was just under seven when admitted to our Children's Service with fulminant symptoms of delusions and hallucinations. He had developed fairly normally to the age of three, when a sister was born. He began to have night terrors. At about the same time he began to have what his mother aptly described as "talking tantrums." He would pace the room, talking angrily to himself about something which seemed entirely irrelevant to his environment. He would mumble "I'm a pussy cat. I'm a pussy cat. Elaine is big. I'm a pussy cat." Shortly after the baby came, he wanted to wear her clothes, and often wanted to wear his mother's. He insisted that he wanted to be a girl, preferred female animals and asked his mother perseverative questions as to why he should not be a girl. At about the same time he began to be afraid of the holes in a fence which he passed, or wherever he encountered any. His father frequently used this fear as a threat, often telling him he would put him in a hole. He tried to get reassurance from his father by asking frequently "Do you love me?"

George became a very good but asocial student. He often spoke of his sister, and again and again of his pet kitten in school. "I have a cat at home. It's a girl cat. I like my cat. I'm a girl cat." His fear of, and wish for, castration could be traced back to his mother's pregnancy. First he developed a strange interest in barrels. He stopped and touched barrels and looked at them with extreme interest. After his preoccupation with barrels he became fascinated by pipes of all sorts which again he would have to stop and touch, commenting on their size, shape, or other characteristics. He would play with his father's pipes for long periods. After a few months he developed a similar preoccupation with electrical appliances. He would endlessly pretend to be plugging in a cord into a socket. Later he developed an intense interest in fires and this was prevalent at the time of his hospitalization. He needed the fire to burn and to kill his sister in his hallucinations—yet in the next breath would profess to love her dearly.

In the hospital his hallucinatory and delusional restitution attempts persisted to incorporate and destructive tendencies toward his sister and mother. In his clearer periods he would state "I'm afraid of killing my mother. I have ideas of wanting to kill her. Yes, I think of killing her, and these thoughts upset me so. That gives me bad feelings in my head. It makes me so upset when I am home. Doctor, you are supposed to take that out."

On the ward he seemed to be hallucinating almost constantly. While sitting next to the nurse whom he loved and hated most, he unzipped his overalls and began pulling at the nurse's skirt as though gathering up something. He then put his hands in his overalls as if pouring in what he had gathered. This went on for a short time, then he zipped up his overalls and sat there smiling. "I've got a Hollinger [name of the nurse] in there . . . that's what I've got in there."

George was hilariously elated for the rest of the day and sat off in a corner, communicating with the introjected beloved (Klein, 1932).

It is obvious that this youngster in his childish way was making the same type of restitutive efforts to solve, albeit psychotically, his bisexual conflict as do adult schizophrenics.

This example of the bisexual conflict before puberty is far from rare. From a repertoire of such cases we select another one.

CLIFFORD age seven was a patient of the Children's Service when he was six and a half with a mixed type of childhood schizophrenia. For the first four teen months of his life, his development seemed normal though he was never a cuddly baby and in retrospect, seemed to have shown the characteristics of a case of early infantile autism during his second, third, and fourth years. At three and a half he became intensely jealous of his eight month-old sister. His speech did not develop. He used stereotype phrasing which he would persevere in a singsong voice and spoke of himself exclusively in the third person. He became obsessed with mechanical and electrical equipment. At five restitutive symbiotic mechanisms became increasingly marked. Whereas up to then he had defended his secluded autistic world now he insisted on sharing his parents' bed and sought close bodily contact with both of them. His bisexual conflict manifested itself in a similar way as that described in the case of George. Clifford began to bite the nurses suddenly and impulsively, for example, when he passed them in the hall. He said he loved the nurses, called them each carefully by name and sought their company for a type of ritualized conversation consisting mostly of identifying them by name and telling his name then naming other personnel on the ward. As his biting was discouraged he began to dress in two handkerchiefs arranged as a skirt, a nurse's cap and insisted: "Don't call me Clifford call me Miss Clifford. I'm a nurse." He became anxious if this was not done and for a period of time insisted on being called "Miss Clifford" or "Nurse Clifford."

This phase of behavior was introduced in the therapeutic sessions by a denial: "I don't want to be a girl. Girls wear dresses, boys wear pants. I don't want to be like my sister. Girls and boys are different." The above was repeated at home, but was quickly followed as in the hospital by the period of insistence upon wearing his younger sister's clothes and being called "Miss Clifford" also by his family.

THE FUNCTION OF AUTISM AS CONTRASTED WITH THAT OF THE MECHANISM OF SYMBIOTIC-PARASITIC FUSION IN CHILD PSYCHOSIS

Whereas in the symbiotic infantile psychosis panic reactions are most prominent, all observers emphasize, in contrast the seemingly self-sufficient contentedness of the autistic child, if only he be left alone. Any approach, any change in the environment, in the social setting, is resented as an irritating intrusion. The autistic position is defended by catatonic-like temper tantrums (Geleerd, 1945). Aggressive and destructive acts seem not to be aimed at the interfering person as a whole. The autistic child shoves away the "hand" that is in his way as he would a wooden block.

What is the nature, what is the function of this pseudo self sufficiency of early infantile autism? It would seem that autism is the basic defense attitude of these infants, for whom the beacon of emotional orientation in the outer world—the mother as primary love object—is nonexistent. Early infantile autism develops, I believe, because the infantile personality, devoid of emotional ties to the person of the mother, is unable to cope with external stimuli and inner excitations, which threaten from both sides his very existence as an entity. Autism is therefore the mechanism by which such patients try to shut out, to hallucinate away (negative hallucination) the potential sources of sensory perception particularly those which demand affective response. If we observe such psychotic children clinically, the most striking feature is their spectacular struggle against any demand of human (social) contact which might interfere with their hallucinatory delusional need to command a static, greatly constricted segment of their inanimate environment⁶ in which they behave like omnipotent magicians (Mahler, Ross, and de Fries, 1949). It would seem that their capacity to master their inner feelings (proprioceptive excitation), their own thought processes, their own motility, their highly selective and restricted sensory awareness, all but overtax their undifferentiated ego. They cannot cope with stimulation from the external world. They cannot mediate between two sets of stimuli. In short, it seems as though these patients experience outer reality as an intolerable source of irritation, without specific or further qualification.

The mechanisms which are characteristic in the *symbiotic* infantile psychosis, on the other hand, are the introjective projective mechanisms and their psychotic elaboration, the symptomatology of which we have described in a previous paper as Group II of "schizophrenia like" clinical pictures in children (Mahler, Ross, and de Fries, 1949). These mechanisms aim at a restoration of the symbiotic parasitic delusion of oneness with the mother and thus are the diametric opposites of the function of autism. As far as our research could ascertain up to date, the lack of separation of the representation of the self from the representation of non self is clinically not discernible in the first two years of life (Jacobson, 1951). Hence clinical evidence for symbiotic conflict of the order and unequivocality which points to autistic disturbance in the first two years of life cannot be expected. But it seems that the symbiotic psychosis candidates are characterized by an abnormally low tolerance for frustration, and later by a more or less evident lack of emotional separation or differentiation from the mother. Clinical symptoms manifest themselves between the ages of two and a half to five, with a peak of onset in the fourth

⁶ This observation was stressed by Dr. Lucie Jessner of Cambridge, Mass. in most helpful personal discussions.

year of life. These infants' reality ties depended mainly upon the early delusional fusion with the mother (unlike those of the autistic who had no reality ties to begin with). Reactions set in, as we described above, at those points of the physiological and psychological maturation process at which separateness from the mother must be perceived and faced. Figuratively speaking, it seems that from the third year onward the growing discrepancy between the rate of maturation of partial ego functions versus lag of developmental individuation causes the brittle ego of these children to break into fragments (Mahler, 1947, 1949). Agitated catatonic-like temper tantrums and panic-stricken behavior dominate the picture; these are followed by bizarrely distorted reality testing and hallucinatory attempts at restitution. The aim is restoration and perpetuation of the delusional omnipotence phase of the mother-infant fusion of earliest times—a period at which the mother was an ever-ready extension of the self, at the service and command of "His Majesty, the Baby." In their stereotyped speech productions one can discern the predominance of hallucinatory soliloqui with the introjected object, and their actions dramatize the same introjective reunion. These are the cases which demonstrate with obtrusive explicitness the mechanisms described by Melanie Klein (1932). The manifestations of love and aggression in these children's impulse-ridden behavior seem utterly confused. They crave body contact and seem to want to crawl into you—yet they often shriek at such body contacts or overt demonstrations of affection on the part of the adult, even though they themselves may have asked or insisted on being kissed, cuddled and "loved." On the other hand, their biting, licking and squeezing the adult is the expression of their craving to incorporate, unite with, possess, devour and retain the "beloved." In other words, the restitutive mechanisms with which they wish to recapture the eluding reality are conspicuously aberrant and different from anything we observe in chronically aggressive, nonpsychotic children, or panic-stricken phobic cases—the two categories which might conceivably pose a differential diagnostic problem (Mahler, 1947).

We cannot better illustrate this desperate attempt to perpetuate the symbiotic fusion when it conflicts with the struggle for separation and individuation, accompanied by the bisexual conflict than in the words and behavior of a patient.

ALMA came to our attention on the ward at the age of fourteen.¹ Onset of her psychosis could be traced back to the age of four and a half. At that time she had a high temperature and was hospitalized for ten days because of measles complicated by pneumonia. Her inclination to "somatization" and to bodily

¹ I owe this material to the co-operation of Dr. William H. Cox, Jr.

symbolization occurred in what seemed to be infantile pregnancy fantasies. These were indicated by the fact that during the entire period of hospitalization of ten days she had no bowel movement. After her return home her abdomen protruded enormously, as verified by several observers. From then on Alma seemed quite different: weak, sick, whimpering and crying. During her first three days at home, she defecated constantly and her abdomen returned to normal size. Following this expulsion of feces, but not during it, she began to stutter. She became fussy about food, consistently refused all solids (warding off of oral sadistic fantasies?) and vomited frequently. She began school at the age of six but seemed to make no friends. At seven, according to her story, an older man made sexual advances to her. It is difficult to determine whether there had actually been an advance of a sexual nature or whether she had interpreted the episode in this way.

At ten, following a bad dream, Alma became very disturbed. Her 'nervousness' followed upon seeing the movie *Snow White and the Seven Dwarfs*. After this movie the patient had a dream from which she woke screaming and ran to her mother. It took a long time and much coaxing to persuade Alma to explain what was bothering her. *She heard a voice saying 'Strangle your mother, strangle your mother.'* She therefore was afraid to sleep in her own room and insisted on sleeping with her father, thereby displacing her mother to another room. She was taken to a psychiatrist at this point.

Alma began to feel that her friends did not like her because something was wrong with *her face*. *She felt* it was too skinny; later she felt that it *looked much older* than her age (approximately the age of her mother). She has become overly solicitous about her mother's health and also overargumentative. On the ward she was constantly looking into the mirror and said that the whole ward (or world?) was a mirror image of herself. She said: 'All things are two substances: soul and sex; some people and some things are primarily 'sex' (mainly women); some people combine the sex and soul feelings together (mainly men). The same feeling I have toward my mother, pertains to sex feeling.' In a letter she said:

*Maybe then [at ten] I for the first time separated from my mother and I was afraid of reality and therefore didn't give it a chance. *And I cut my self off and forgot soul feelings. Like maybe when I saw 'Snow White and the Seven Dwarfs,' somehow I was the witch and fed the girl the apple—and I saw the prince and I saw soul and sex feelings which (feelings) in reality concern men—Maybe somehow I wanted to get my mother out of myself by strangulation and at the same time strangling or punishing myself [for and by] killing Snow White—All I know is after I said 'Strangle your mother,' subconsciously I equated my mother to the witch and sort of broke away from my mother. I felt weird inside, strange empty, an afraid weirdness. [Then] I was no more afraid of myself anymore for a few seconds. But for a whole year I constantly*

* We know from the anamnesis that in fact the first real separation and prepsychotic reaction to facing reality apart from mother occurred when Alma was four and a half years old.

*threw up and always felt like dizzy*⁹ Maybe subconsciously I was strangling my self (as the witch) or was it mother—or was it Snow White—or was it the mice that Ma killed¹⁰—but I imagine it was me—I thought I would sleepwalk and kill her¹¹ After a few seconds I didn't feel empty but different "

One could hardly ask for a more explicit description of the steps which introduced the gradual loss of reality, the psychotic break with reality, and the subsequent restitution mechanisms in this symbiotic psychosis. There is confusion between the self and the mother and a lack of direction between libidinal and aggressive tendencies. Both the mother and the self are confused and fused as the goal of unneutralized instinctual forces.

The introjected persecuting mother makes Alma fear that she looks much older than she is, she has sex feelings toward the mother, has the impulse to strangle the mother—in herself and in the outside—and then she says either that she is her mother's mirror image or again that the world is her own mirror image. "It is as if I have to live with my reflection (like when I look in the mirror) [the mother in herself] and I have to face my reflection when I see people because they are my walking or live reflections." The fusion of all three representations—self, mother and world—is expressed in her own words: "What if I am the living reflection of my mother and when I look in the mirror it is a double exposure. And I see my reflection in others and it makes me miserable."

I go around in circles. There is no escape. I live in a world that has a plane surface, flat like my reflection in the mirror and the people I see in this world are the living reflection of myself and this sex person that I see in the mirror isn't me. I refuse to accept that person."

The crux of the pathogenic struggle to give up the symbiotic parasitic fusion with the parental image is clearly expressed, and the Kleinian mechanisms are strikingly illustrated by the patient when she says: "After I said 'Strangle your mother,' subconsciously I equated my mother to the witch and sort of broke away from my mother." "But for a whole year I constantly *threw up* and always felt like dizzy. Maybe subconsciously I was strangling myself [or the mother in herself] and felt guilty for strangling myself—or was it mother—or was it Snow White [whom the witch tried to kill]—or was it the mice that Ma killed—but I imagine it was me. After a few seconds I didn't feel empty, but I felt different."

⁹ We again know from the anamnesis that this vomiting off and on and refusing solids (in warding off obviously oral sadistic incorporative fantasies by ejection) began at four and a half.

¹⁰ Alma was horror stricken when her mother actually exterminated mice in their kitchen.

¹¹ This was the rational reason Alma gave for sleeping with her father to be protected from her dangerous impulse.

This is but a brief excerpt of the wealth of material this young girl produced. Though these productions stem from a time when she was an adolescent, we cite them here because she was actually describing the genesis of her psychosis in retrospect (as verified by her mother, sister and father) and because with her queer talent for introspection she has described all the aspects and functions of the symbiotic parasitic hallucinatory mechanisms of restitution.¹²

DIFFERENTIAL DIAGNOSTIC CONSIDERATIONS

I believe that the two types of infantile psychosis—the *autistic* versus the *symbiotic*—can in many cases be clearly differentiated in the beginning. Later the pictures tend to overlap. Differential diagnosis in retrospect may be attempted by reconstruction and appraisal of the earliest mother-infant relationship. The specific factor in differential diagnosis is the mother's role as reflected in the baby's nursing behavior during the process of individuation during the period when the infant's body-ego and representation of the self should emerge from the primal somato-psychic symbiotic stage and the fused representation (Jacobson, 1951). As described above, the autistic baby behaves quite differently during the nursing period than either the normal infant or the symbiotic baby. We stated that the primarily symbiotic child often cannot be detected before awareness of separateness from the mother image throws these infants into a state of panicky separation anxiety. When we meet cases of child psychosis at a later stage, it seems that pure cases of autistic child psychosis as well as pure cases of symbiotic parasitic psychosis are rather rare, whereas mixed cases are frequent. By this time, symbiotic mechanisms have been superimposed on basic autistic structures and vice versa.

CLINICAL COURSE, TREATMENT AND OUTLOOK

We can make only a few tentative formulations on these most important points.

As somatic and physiological development takes its course, there is no conceivable human environment in which the autistic child could maintain his shell against the demands of the outside world. Indeed, the prerequisite of personality development and the first requirement for treatment of the autistic child, is to lure him into contact with a human love object. At that point of development or of treatment, reactions which resemble parasitic symbiotic mechanisms appear spontaneously or as an artefact of treatment.

¹² They are identical with those in symbiotic cases like George's, Betty's, etc. whom we studied or analyzed respectively from the age of five to eleven (Mahler, 1947).

On the other hand, children who begin with a symbiotic psychosis will use autism as a desperate means of warding off the fear of losing whatever minimal individual entity they may have succeeded in achieving, either through development or through treatment, which they then attempt to preserve by the opposite psychotic mechanism of autism¹³. Thus we often see children whose psychosis had primarily the characteristics of a symbiotic disturbance, but who then used autism in a desperate attempt to ward off the threatened regression into symbiotic fusion to preserve individual entity, separate from the mother or father¹⁴.

It is essential to differentiate diagnostically between basically autistic and symbiotic disturbances, because in each case therapy must follow different principles. It seems that in both types, as well as in the mixed type of early child psychosis, it is essential to keep in mind the extreme brittleness of the ego¹⁵.

As we mentioned above the *autistic* child is most intolerant of direct human contact. Hence he must be lured out of his autistic shell with all kinds of devices such as music, rhythmic activities and pleasurable stimulation of his sense organs. Such children must be gradually approached with the help of inanimate objects, always keeping in mind that gross bodily contact, touching, cuddling—which one might expect would reassure a deeply disturbed child—is of no avail and often a deterrent with these autistic children. Time and again we see that cases of the autistic type, if forced too rapidly into social contact and into facing the demands of the social environment, are thrown into a catatonic state and then into as fulminant a psychotic process as we see in some of the symbiotic child psychoses.

In the *symbiotic type*, on the other hand, it is important to let the child test reality very gradually at his own pace. As he cautiously begins this testing of himself as a separate entity, he constantly needs to feel the support of an understanding adult, preferably the mother or the therapist as mother substitute. Such continual infusions of borrowed ego strength may have to be continued for a lifetime¹⁶. In other words, *separation as an individual entity can be promoted only very cautiously* in the case of the symbiotic psychotic child.

¹³ Compare Anna Freud's beautiful paper, "Negativism and Emotional Surrender" (1951).

¹⁴ *Ibid*.

¹⁵ The autistic group corresponds with Group I in our previous paper (1949). We deliberately have not dealt in this paper with our Group III of child psychosis (Mahler, Ross and de Fries 1949), the clinical pictures of which in latency were recently described by Annemarie Weil (1952).

¹⁶ This opinion is shared by Paul Hoch who stresses the necessity of possible lifetime substitution therapy in certain cases of adult psychotics.

Prognosis as to the arrest of the process and as to consolidation of the ego is moderately favorable. It seems to depend on the right type, and the cautious, prolonged and consistent nature, of the therapy, which is a kind of substitution or infusion therapy. However, the outlook as to real cure is bleak. In cases of *symbiotic* infantile psychosis the development of individuation has been missed at a time when essential, basic faculties of the ego are usually acquired within the somatopsychic matrix of the primal mother-infant unit. In our experience, if and when differentiation in this matrix, highly specific for promoting sound individuation, is missed, the ego remains irreparably warped, narcissistically vulnerable, unstructured, or fragmented.

In the *autistic* type of infantile psychosis the deficiency is even more severe because the *specific matrix itself* was nonexistent, and therefore the growth which it fosters, could not take place. Establishment of contact and substitution therapy over a long period of time may sometimes give spurts of impressive and gratifying results. But they are usually followed by an insuperable plateau of arrested progress, which usually taxes the patience and frustrates the renewed hopes of the parents. Impatient reactions and pressures are then exercised and progress forced. But, as we said before, if the autistic type is forced too rapidly into social contact, and particularly if the newly formed symbiotic relationship causes frustration, he is often thrown into a catatonic state and then in as fulminant a psychotic process as we see in some of the symbiotic child psychosis cases, when separation anxiety causes the latter's brittle ego structure to break into fragments. As I have described in a previous paper, if such catastrophic reactions cannot be avoided, it seems that such autistic infants are better off if allowed to remain in their autistic shell, even though in "a daze of restricted orientation" they may drift into a very limited degree of reality adjustment only. Diagnosis of their "original condition," of course, then usually escapes recognition; they are thrown into the category of the feeble-minded.

Any pressure in the direction of sudden separate functioning must be cautiously avoided in the *symbiotic* child. If the ego of the symbiotic type is overrated and expected to be able to cope with reality without continual ego infusion from the therapist, who substitutes for the mother, the panic reactions and acute hallucinations may cause regressions and withdrawal into stuporously autistic states or hebephrenic deterioration. Therefore simultaneous supportive treatment of the mother, if at all possible, seems to constitute the optimal and, perhaps, even a *sine qua non* approach to the problem.¹⁷

¹⁷ Compare also the opinion of Beata Rank and her co-workers (1950) as well as the works of Melitta Sperling (1951), Eikisch (1952), and others.

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DISCUSSION OF TECHNIQUES USED TO PREPARE YOUNG CHILDREN FOR ANALYSIS

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It is not an infrequent experience in the practice of child analysis to find that the initial steps taken to win the child for psychoanalytic work have influenced the entire course of analysis. In many cases, the preparation for analytic work is longer than the analysis proper. Essential steps in growth must be made before interpretation before the verbal and direct approach to resistances and the uncovering of unconscious content become possible. This explains why nonanalytic techniques have to be used with many children before they can communicate by play, fantasy, or direct verbalization. Other children, already well versed in these means of expression and communication, may have to be approached by less verbal methods in the beginning of treatment, particularly if what appears to be adequacy is actually counterfeit, the result of spurious maturation.

The preparatory phase of analysis was of great importance in the rehabilitation of the children whose cases will be discussed in this paper. The group is not, however, homogeneous in symptomatology, in the extent of disturbed ego functions or in the degree of their capacity to form object relationships. There seem to be no common characteristics with regard to decisive pregenital fixations, nor can the children be diagnosed as psychotic or defective.

Review of the developmental histories of the children shows that maturational patterns, in the sense that Hartmann, Kris and Loewenstein use the term, had not been established in the expected sequence. It seemed that preparatory work became analysis only when the children had mastered the steps in growth and maturation which are implied in the term latency period as a developmental diagnosis.

In the first case, the child's high intelligence and her intense responsiveness had resulted in a picture of pseudo maturity. Pushed toward accelerated progression, the child's tolerance for direct gratification had been lowered critically. It had to be restored in preparation for analysis. In the second case, prolonged preparation was necessary because certain

through the house continuously and frantically tried to cover the tracks of mother and brother at the same time. She became distended and had frightening dreams and nightmares, which changed to sleeplessness upon the mother's insistent attempts to elicit the dream contents from the child. The child's cold persisted as did her refusal to blow her nose.

The child was born at full term. During pregnancy the mother had been physically well but euphoric. Delivery was remembered as the brutal shock of having the baby torn away. A mild postpartum depression soon gave way to the mother's pleasure in the infant's perfection. In infancy the patient had been healthy, never too interested in feeding or cuddling, but precocious in intellectual and motor development. She began to talk at seven months and to walk soon thereafter, without the intermediary stages of baby talk or crawling. The mother poured the full energy of her former intellectual pursuits into the companionship with the child. The relationship between mother and daughter was most intimate in their mutual fantasy games and their later "adjustment sessions." The mother's delight in the child's brightness, originality and early sophistication was genuine and unrestrained. She feared that the father's lack of appreciation might dampen the qualities which she cherished in her child. Mother and daughter accepted the father's attachment to the younger child, a son eighteen months old, without protest.

During the mother's second pregnancy our patient's progress had become even more accelerated. She seemed to understand all explanations perfectly. Her vocabulary grew to encyclopedic proportions. She also relinquished all claims to be cared for like a baby.

The patient was graceful, attractive, and had excellent manners. In repose her face was sad and had an old expression. She talked readily, calling me a dear friend because I had invited her to see such beautiful toys. Her smile appeared readily when she was spoken to but remained absent when she was smiled at. She asked me to smile only when she had said something bright. When she assured me, spontaneously, that she was going to tell me all her thoughts as her mother had instructed her, she swallowed air and became distended. She praised the toys, which she did not touch, and ended her first visit by a long recital of poems "for grownups." When she joined her mother after this first meeting, she described the wonderful time she had had playing with more toys than the mother had ever seen. She also informed her mother that she had learned to read, write, spell, count, sew, knit, cook and had told me all her stories and troubles.

The analytic approach to the content of a child's unconscious conflicts is essential for their ultimate resolution. This approach is, however, contingent upon a child's ability to communicate in ways appropriate for the analytic method. One of the prerequisites is a child's ability to use the powers of intellect for other than defensive purposes. At the on-

set of treatment, however, all intellectual elaboration had become full of conflict for our patient. Intellectuality had turned from one of her most valuable props into an obstacle against gratification. Intolerance for regression, combined with the mother's stress on advanced intellectual performance, had always diminished the child's ability to obtain the kind of gratifications for which she now envied her younger brother. In some measure, this deficit had been compensated for by the close contact with the mother in their intellectual exchanges. Upon the mother's insistence on the topic of death wishes, however, talking ceased to be a comfort and became a threat. This occurred at a moment when the child possessed no other, equally effective means of overcoming isolation. Prevented from exercising her established form of mastery and habitually blocked from expressing demands regressively, she resorted to mechanisms of somatization for her current solution.

These circumstances determined the method of approach. Before analysis could begin, the child had to be provided consistently with opportunities for experimenting with other than her habitual and pathological mechanisms for assertion and defense. Since, for our patient, verbal communication had become a threat, it was necessary in the initial phase of treatment to establish trust and confidence by relying on more primitive, nonverbal, modes of interaction. It was thought advisable to confine therapeutic efforts during the sessions to those aspects of reality which were evident to both patient and therapist. In such a setting, even the less crippling mechanisms could only gradually emerge, and analytic work had to be postponed until these new forms of mastery were sufficiently cathected to enable the therapist to demonstrate their greater effectiveness to the child. In this state of coexistence of new and old methods, confrontation and subsequent analytic work would become possible.

In the first phase of treatment, the child attempted to engage my interest by relating stories of little girls in foreign lands. Regardless of their nationality, all these little girls sang and danced to the admiration of a happy family of mother, father, and little brother. If I questioned her, she would merely transpose the story to a different country. She described all personal interaction in a rigid and stereotyped way, performed songs and dances ceremoniously, but related details of scenery expertly. She pretended to wear a variety of costumes, her first story always matching the costume she "wore" on that particular day. She consistently "forgot" to wear an Eskimo costume which she mentioned frequently. She rejected all toys as too easy, with the comment, "Don't forget, I am bright." Later on, she rejected the same toys as too difficult, explaining that she was "too little, but a young lady." Still later, she proclaimed herself "plain too little" and admitted her fear of failure. To her, sharing ac-

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tivities meant watching and praising each other's skills, yet even this kind of interaction became too threatening to her at the onset of treatment. For a long time compulsive requests for my explicit admiration preceded any activity

After about three months of treatment, she became interested in a pounding bench, which she used for many sessions. She claimed that she had owned one just like it when she was a baby, but it had been given away because she had grown too bright for it and also because her mother had then, as now, disliked the loud noise of pounding. Recently her brother had been given the identical toy. Now he and father had fun pounding together, while she and mother sang or talked in a different room. She requested that we both sing and pound and berated my inability to do either as well as she, and then sang solo while she pounded alone. When I refused to sing with her, she asked her first personal question of me and began to address me by my name. First she dropped the solo singing and spent several hours pounding happily and with increasing vigor. At this point abdominal distention disappeared, but its meaning became clear only in a much later phase of her treatment. At this time she also decided to drop the communiques, often fictitious, which she had given her mother after each session. Her first explanation was that her mother would not think we were doing anything since we were not talking much. She became distended at the conclusion of this session, later she described her new reticence as fun and had no distention upon leaving.

This beginning independence from her mother was based on a clearer definition of her sense of identity. It became possible for her to emerge from her former symbiotic attachment to her mother sufficiently to go through a period of regression and regrowth in the course of several weeks, following which true interpretative work was begun. Her greater independence was signaled by a change in her recitals. Instead of caricaturing her mother's tone of voice, she chanted nonsense words and began to hop and skip far more artlessly but in a much more lively manner than her former folk-dance style. She dared me to guess the meaning of her neologisms, keeping them secret with triumph. She began to talk about her Eskimo costume. Drawing a clear distinction between her own tastes and her mother's ideas, she explained that she and mother disliked this outfit for different reasons. The mother disliked it because she did not like Eskimo songs. The patient disliked it because the costume was too big for her. She liked clothes to be just a little on the small side. She would like to wear her old outgrown dresses over again and imagined how she would sneak into some of her brother's clothes behind her mother's back. She remembered that the mother had frequently offered

the brother's baby clothes, his bottle, and even his diapers to her. She, however, wanted shoes, slacks, and dresses that had been right when she could walk, talk, and go to the toilet by herself.

In the course of continuously elaborating this fantasy which had come to the fore in connection with the Eskimo costume, she gave up her extreme concern for neatness and for matching accessories. She dropped the idea of costumes altogether when she was able to tolerate and to combine aggressive and infantile needs in herself. Then, detachment and delegation became unnecessary.

For some time she engaged in repetitious play activities. She divided the office into two igloos, I was confined to my igloo, the study, while she had the run of the playroom. I could enter her domain only on her request, but she reserved for herself the right to come into the study whenever she pleased. I was permitted to ask no questions and to reply to her only in English, but she could talk Eskimo, French, Swedish, Hawaiian, or nonsense, English was to be used only when she felt like it. Her igloo contained only 'things for children, which I was not allowed to touch unless she asked for help, but she demanded free access to my books and papers, and to the candies in the desk drawer.

This clear delineation of territory and function was a further step forward in establishing a more independent sense of identity. She expressed her need to grow up with the help of adults, but at her own rate, and without adult intrusion into her fantasies as the prize for their help. At first her igloo became the setting for more elaborate adult activities such as tea parties, to which I was invited. Periods of retirement to her igloo became more frequent but of shorter duration. Returning to me became as important as isolating herself. She varied the length of her retreat from me in order to test my willingness to resume contact with her again. She spent some time exploring the shelves of the playroom thoroughly and by herself, discovering baby bottle and diapers which had been there all the time. She demanded to be held, patted and belched, she drank from the bottle and talked about soiling herself. Some of this activity carried into her life at home. For a time she demanded to be spoon fed occasionally, but she kept her usual table manners when eating in company or with her parents.

She then reversed the division of camps, using my office exclusively for babyish activities and retiring to the solitude of her igloo to practice various skills like weaving or knitting on a spool. The barriers by which she maintained this strict division between our respective territories served defensive purposes. They protected her against the threat of a symbiotic relationship and signified attempts to isolate mature from infantile, and good from bad.'

The continuous and predictable qualities of the therapeutic atmosphere had permitted her to recapitulate certain aspects of infantile gratification. Thus her ego strength was increased, but by educative rather than psychoanalytic measures. The following incident demonstrates her new ability to subject destructive wishes to reality testing. With the ability to differentiate between good and bad within herself, the compulsive mechanisms of isolating became unnecessary and the barriers disappeared.

On this day she called me into the playroom and showed me a doll which she had thoroughly demolished. She emphasized that she had done this by herself and that she knew she had destroyed a doll and not a child. The doll had not been real, like a child, but her anger had been real, and what she had done had really happened here. She did not like what she had done and I did not have to like it either. But she was glad that she had really broken a real doll. Now she wanted to learn more about how to be careful and have fun.

She had tested my capacity as a nonintruding listener, my tolerance for her babyishness, and my willingness to recognize her destructive tendencies together with her wish to master them.

In the course of subsequent interpretative work, play, drawings, dreams, and fantasies were used in the usual manner. The symptom of distention, which she called "blowing thoughts," returned temporarily as resistance. It had been her only successful attempt to withhold thoughts from her mother and to store fantasies within herself. The symptom had counteracted the fear of becoming depleted by the mother's constant request to share with her all intellectual productions and emotional strivings. The symptom also expressed pregnancy fantasies—her wish to retain body content against the threat of being penetrated and robbed by the mother. Although sex information had been given by the mother conscientiously, the child's fantasies had elaborated not what the mother had told her, but the manner in which she had spoken. The child believed that babies grow from sounds which enter through the ears and into the heads of mothers, fathers, or children. Little girls lose the babies when they blow their nose, which their mothers tell them to do during a cold. Swallowing mucus and the air that carries the sound prevents this loss.

In the *second case*, a six-year-old-boy, the prolonged period of preparation was characterized by progressive mastery over motility and perception. Preparation led to his ability to produce memories. This step in ego development made it possible to use psychoanalytic methods in his treat-

ment. Mastery of an actual experience, which on retrospect assumed the significance of a screen memory marked this event

The patient was the second in a family of four children. The three brothers had been born at intervals of two years. The youngest child, a girl, was four months old when the patient started treatment. The parents were concerned about the patient's violent attacks on his mother, his baby sister and the maids, and about his poor adjustment in school. He fought excessively, refused to comply with any routine, and had failed to acquire the rudiments of learning. His speech was infantile, he suffered from an atypical, intermittent form of strabismus which could not be corrected by glasses. Some of his teachers suspected mental retardation, but because of his violent objections, he had not been tested. Attempts at eye exercises, speech therapy, and psychotherapy had been disrupted by his violent behavior.

The patient had been the biggest and most vigorous of the children in the family, resembling the father in appearance more closely than did the other children. The mother felt guilty that he was the only one of her children whom she had neglected in infancy. In order to protect her oldest son, who more closely resembled her, from feeling displaced by the newcomer, she had given the second child a minimum of personal care. She remembered also that the second child had always frightened her because he became violently excited whenever she picked him up, until finally she dreaded to do so. The intensity of his need seemed to have led to a restriction of the mother's attention and care for him, giving them a tentative character. Except for these intervals of intense excitement, the patient thrived and seemed contented. Feeding and training were uneventful. He remained a voracious eater. Except for some slowness in walking and talking, he developed adequately until the birth of his younger brother. There had been no major illnesses or operations, but he showed a tendency to develop severe reactions to colds whenever he was separated from his mother.

The boy was tall and well built for his age. He had a fierce and frightened expression, movement and speech were clumsy. During the first period of treatment he reacted violently to leaving his mother in the waiting room, throwing himself on the floor, clutching her knees, looking at her imploringly and with crossed eyes, and wailing loudly. He concluded these scenes by sitting up with his back against her knees. The stereotyped sequence of events did not occur when his nurse brought him to my office. After such outbreaks he would often follow me into the office on all fours.

In the treatment room the childish pull toys attracted his attention exclusively. He crawled on the floor and investigated everything he could see from this position, apparently not perceiving anything else around him. In the tenth interview he discovered a step ladder in which he became most interested. For many sessions he practiced climbing the lad-

der, and with my help gradually overcame his excessive clumsiness. When he could climb quite well, he still reiterated his fear of falling. He also feared that he might forget how to climb from one session to the next. For many sessions the highest step of the ladder became his headquarters. He demanded that I sit on a low chair close by. From this position, and on his request, I fed him great quantities of candy and many baby bottles. He kept a watchful eye on me, insisting that I turn my head away when he ate or drank. Perched on the ladder, he began to paint. It was his idea to attach a sheet of paper to the wall and to install the paint jars on the ladder. In this position his progress was surprisingly fast, while his activities on the floor or in other positions remained quite clumsy. Gradually he began to descend to lower regions for longer periods, until the ladder became only an occasional refuge.

For many sessions his closest contact with me was pushing toys back and forth between us. Then he began to use a spinning top and other mechanical toys. He asked me to put them in motion and tried to see how quickly he could control and stop them. He instructed me in a system of signals which gradually became more complicated, and took great delight in obeying them. Then he took over the responsibility of setting limitations and called the signals himself. Thus, beginning internalization led to self-regulation. Improvement in motor co-ordination was striking and carried over into the performance outside of our sessions. During later stages of treatment, motor disorganization recurred whenever he experienced surges of hostility or demands of excessive intensity. These attacks of clumsiness were dealt with as resistances. They did not affect his performance outside our sessions.

After he had established some measure of control he ventured to display occasional temper outbursts toward me, after which he retreated to the ladder. The temporary appearance of compulsive defenses marked the end of these flights and indicated progress. A more elaborate but less energy-consuming mechanism had been substituted for primitive discharge and magic control. In a further step of experimenting with mechanisms of control he began to use the figures of animals instead of mechanical toys. He staged scenes in which animals were fed and cared for but was most interested in having them restored to these cages from which they had escaped, with much violence and despite punishment. He assigned himself the job of assistant headkeeper of the animals and consulted me about restrictions and punishment. Later he appointed himself chief headkeeper of the rapidly expanding zoo.

He learned to model with clay. One of his first creations, a little snake, became his constant companion during our sessions. He treated it with a gentleness that was new in him, taking careful precautions for its safety

in the zoo, and assigning it a special box in which it was to stay between sessions. While all attempts at connecting this play more directly with his own experiences and fantasies remained futile, his progress in co-ordination and attentiveness at home and at school continued. Temper tantrums had become a rare event, and his clinging to the mother in the waiting room had quite disappeared. He tolerated a prolonged separation from her without becoming ill, in further contrast to his previous behavior he spoke regretfully of her absence and anticipated, and made plans for, her return with pleasure. His strabismus, however, was more marked during the mother's absence and he overate considerably. The latter two symptoms did not recur during later separations from the mother.

When the mother brought the patient to the office on the day of her return, he repeated the behavior he had originally shown in the waiting room with one exception: he did not crawl into the office nor rush up the ladder, but walked in with me. He repeated the waiting room scene with me. After much sobbing and in the infantile speech which had become unusual for him after the six months of treatment, he complained that he had fallen over sideways and asked me to put pillows on either side of him, which I did. His sobs stopped and he declared triumphantly that he had grown and could see me. Since he had not actually turned his head toward me, I asked him to turn around and really look. When he did, he performed an important step in reality testing. In the same session he remodeled the little snake into a boy to whom he gave his own name.

He produced a long, coherent fantasy which explained to him why he had to be so bad when he first came to see me. He had feared for a long time that his mother would sell him, that is, going to give somebody money to take care of him because she had too many children to take care of.

He was speaking of his lack of personal identity and of status in the family group when he gave the following reasons for the mother's intention to get rid of him. She loved the older brother most because he was her first child, she was going to keep the second brother because he was her youngest son. His sister was particularly fortunate, she was doubly protected against being sold by being the only girl and the youngest child of all. His only disunction—that he was had more often than the others—was an additional reason why his mother wanted to get rid of him. To be given away meant to become very tiny, helpless, unable to walk. Also, he would be unable to see his mother, as he had been at the time he had fallen down. He recalled that he had liked to run into his mother's room to hug her. Once when his brother had just been born and his mother was feeding him on the couch, he had fallen down in

front of them. His mother picked him up and sat him down on the floor. He tumbled over and she put high pillows next to him. It got dark and he could not see her. He screamed because he was scared and a strange maid carried him out of the room. Later his old play-pen was put in his mother's room and he had to sit there when she nursed the baby. He could not see them very well but watched anyhow. To show me what he meant, he turned his head up and crossed his eyes. He also remembered how he had laughed and been happy whenever he rushed toward his mother. The play-pen, he now knew, had been used again only to prevent him from falling when the mother was busy with the infant. But it became clear that this measure of protective custody had frightened and enraged him and forced him to revert to crawling.

The child's preferences for sitting on the ladder and for crawling on the floor can now be viewed as attempts at mastering a traumatic situation which contained many elements characteristic for the chronic deprivation for his early infancy. Perched on the ladder he was not only taller and more powerful than his adult companion, he was safe. He could keep a constant, watchful eye on me while hiding his greed by asking me not to look at him while he ate. He crawled instead of walking and played with me on the floor only to assure himself that he could choose regression autonomously, and that it did not lead to exclusion and loneliness. He had rushed to the mother to be close to her, to watch the feeding of the baby, and perhaps also to interfere with this event, which made him jealous. Unable to integrate all these wishes, the mounting tension may well have affected his newly acquired motor co-ordination. His intense onrush became his virtual downfall. Confinement to the play-pen disrupted all closeness to the mother; tangible contact with her would have been gratification in itself as well as reassurance against the destructive qualities of his greed. The measure of confining him was additionally traumatic because it had occurred after he had already triumphed over the space which had isolated him from his mother. The enforced inhibition of his activities created anxiety for internal reasons, as well as rage over his helplessness and against those who confined him daily. His crawling thus bore the stamp of desperate submission.

While the incident had been traumatic, the memory of the incident had also a protective meaning. In the memory of the circumscribed event, feelings were differentiated which formerly had been vague and engulfing. This differentiation represented activity and made him less helpless in the face of loneliness. The memory also protected him from being overwhelmed by unmanageable quantities of rage at unpredictable moments. Establishment and utilization of conscious memories indicated his progress in functioning in line with the secondary process. This is the

fundamental reason why it was possible from this point on to apply psychoanalytic methods

The boy dared to remember only after he had learned to master, during successive stages of the preparatory phase of his rehabilitation, the vague but powerful underlying traumatic forces. The appearance of memories indicated that he had made significant steps in ego development. This gain was the basis for his further growth in the course of psychoanalytic work and the condition under which such work could begin.

The third case. A five-and-a-half-year-old boy was brought for treatment with the following complaints. In the course of the past two months he had developed the habit of disappearing from his parents' sight by squeezing himself into tight places without ostensible provocation. At other times and apparently with as little provocation his voice assumed the strained character of a hoarse loud stage whisper. He had become unduly modest, refusing to undress on the beach and not tolerating the presence of others during his bath or when he went to the toilet. His adjustment to school and to his contemporaries did not seem to have been affected. Sleep and appetite were undisturbed nor had his ways of getting along with his mother, father and siblings changed.

The child had developed normally until the age of eighteen months when he was diagnosed as suffering from celiac disease and put on the usual restricted diet. He had frequent severe attacks of diarrhea and within a few months of the onset of his illness developed a recurrent rectal prolapse. Dietary restriction was the mother's responsibility while the father undertook the replacing of the prolapse. In neither event did the patient show alarming reactions. Physical growth proceeded adequately; toilet training was reestablished on his own request. Even during attacks of diarrhea soiling did not recur. At the age of two and a half he began a successful career at nursery school. He became his own dietitian, planned his menus within the necessary restrictions and brought his special diet to school with him. When he was four years old all dietary restrictions and the idea of surgery were given up. After a few months of further progress he was declared well. Prolapse and diarrhea had not recurred.

During the first year of the new regime he made rapid progress in all areas. He caught up in his somewhat retarded speech development, learned many new skills, seemed happy and on free terms with his parents. He had reached a height of adjustment when the presenting symptoms appeared.

The area and the degree of his pregenital fixation determined the intensity and the content of his castration fears and the difficulties he encountered in resolving the oedipus complex. Oral deprivation had been sudden as well as extreme during the acute phase of his illness; he had suffered the physiological concomitants of starvation. He had connected these experiences with his mother's care for him. He blamed her for starving him by insisting on his diet and thought that she was causing his diarrhea because she wanted to deprive him of the little she gave him.

or to punish him for stealing forbidden food greedily, or to poison him by introducing new foods which made him ill. When he had taken over his own dietary management it was with the unconscious intent of safe guarding his relationship with the mother, but since diarrhea recurred, this attempt was only partially successful. Seen through the rage of oral deprivation, the mother appeared as a threatening robber. The father's role was in sharp contrast. The child regarded him as a benign helper whose replacing of the prolapse restored body content lost through diarrhea. The father became in this way a powerful guardian over physical integrity. Sensuous stimulation in the course of rectal manipulation furthered submissive attitudes toward the father. Since the vicissitudes of his physiological function prevented him from controlling intake and elimination autonomously, both parents retained great powers over him. But as long as the parents' magical powers were in balance he was protected sufficiently to function and to learn. When dietary restriction and rectal manipulation ceased, an immediate crisis did not arise because he had incorporated the parental images in their different roles. Integration was further maintained by many rituals, and by widely spread compulsive mannerisms of perception, thought and gesture, which he had performed unobtrusively and which were revealed in the course of treatment. Oral deprivation had occurred at a time when he had progressed beyond the ability to develop oral substitute gratifications for the release of tension. The anal overstimulation occasioned by replacing the prolapse occurred after the training experience, during which an important component of his anality had already been relinquished. The sudden change in the amount of gratification caused fixations in both areas, explaining the delay in the appearance of phallic strivings. But when the competitive and destructive wishes did appear, the former magic balance was threatened. The father became invested with powers of retaliation. In this light, anal manipulation by the father was remembered as a dangerous attack on protruding body parts. When he squeezed himself into tight places, the patient re-enacted with his entire body the replacing of the prolapse and attempted to ward off the threat of passivity. His strained voice was a displacement of the straining which had produced the prolapse, as well as a disguised attempt to seduce the father. Both symptoms, the hiding and whispering, were released by anal sensations, which accompanied unconscious fantasies of retaliation and wishes for seduction. This connection became obvious only after prolonged preparatory work.

The first aim of treatment was to permit the emergence of alloplastic mechanisms. The personal interaction in the therapeutic atmosphere was to be simple enough to allow other than magical solutions. This was

ved to some measure when the patient began to include the therapist exercises of hoarding, retaining, sorting and substituting, after keeping self isolated through our initial sessions. He entered these activities gradually and with much hesitation, he performed them rigidly and ungently without affect at first, then temporarily with expressions of depressive rage. During the first months of treatment he disregarded all except paper, paint, scissors and glue. He was distant and conforming in his behavior, and seemed impervious to praise, appreciation, criticism or suggestions that he communicate fantasies, dreams, thoughts and daily events. He spoke only rarely and also had no questions to ask me. His symptoms remained unchanged and were never produced during our sessions.

After some time he began to accompany his activities with many grimaces, indicating in simplified speech whether the grimaces were meant to threaten or to amuse me. He held himself aloof from all physical contact, and it was he who initiated and discontinued our conversations. My rebuffs were accepted, but after a while my wish to understand what he meant by his grimaces intrigued him. He insisted first that I was only guessing and did not know the meaning of these faces. Then he began to believe that I did not, and announced that try as I might I would not understand the grimaces until he told me about them. This I accepted for a moment and the grimaces continued. One day he ordered me to draw two faces and to designate them as 'stop' and 'go' respectively. He suggested that we color one face red and the other one green, but because he did not yet trust me in matters of control, he insisted on outlining them with thick black circles himself.

Communication remained limited to a few areas of his choice but became freer in tone. He began to draw and color various geometrical shapes, he cut them out with meticulous care and in great quantity, sorted and arranged them in various piles, hoarded them, asked me to save them and cautioned me against interfering with them in any way. Later he gave me careful instructions as to size, shape, color and number of cuttings I was to produce. He saved them in boxes and counted them as soon as he came in and again before he left. This was the extent of communication after several months of treatment.

He began increasingly to include me in his mass production, decreasing his demands for accuracy and cleanliness. He began to eat candy, rationing himself rigidly and displaying many rituals at first. Once, when he had started a new collection of highly suggestive plasticene forms, painted an equally suggestive brown, he got flustered and suddenly disappeared in the narrow space between shelf and wall. He denied that the shape and color of his production could have something to do with

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his embarrassment and threatened to leave me forever. After a lengthy period of contemplative silence, he asked shyly and submissively whether I would help him with the pounding bench, or whether I wanted him to do it himself. I suggested that he try it by himself but assured him of my help if he needed and wanted it. He did not decline, but he postponed the project until the next session and departed promptly. He used the toy for many subsequent sessions to recapitulate in rapid succession many elements of his former behavior, his conforming, his grimacing and stilted rage. He accepted my reference to previous incidents when he had had to behave similarly and occasionally pointed such connections out himself.

Confronting a child with the "here too" and "now again" is limited to experiences shared with the therapist. This limitation distinguishes it from the technique of working through used with adults or older children. The modification is necessary because the young child's relationship with the therapist is, to a larger extent, of a realistic rather than a transference character. In contrast to transference reactions, which are motivated by the repetition compulsion, the realistic elements in the therapeutic relationship have a high degree of plasticity and are amenable to change. They mature within a therapeutic setting which provides the condition and the duration for such growth.

This consideration gives additional significance to the prolonged preparatory period inevitable in many child analyses. As treatment proceeds, former phases of the child's relationship with the therapist as a real object are analyzed. The child is confronted with techniques of control, manipulation, approach and retreat which he had used in the past in relation to the therapist. It is possible to show the child as one does the adult that these mechanisms, previously useful or inevitable, have become unnecessary and are less rewarding than the new forms of mastery he has acquired. The extent to which intermediary steps are demonstrated explicitly depends on the intellectual maturity of the child and his ability to verbalize. In younger children and in those who still misuse verbalization and intellectuality for defensive purposes, this awareness of growth is transmitted implicitly and nonverbally.

Our patient not only recapitulated his old mannerisms during his play with the pounding bench, he also made new gains and discoveries. He expressed his conflict more directly as he used the toy for an individual purpose rather than in conventional ways: that is, by stuffing into the openings of the pounding bench claw, instead of the wooden pegs which belong there, or by inserting the pegs at the distal end of the bench. He began to eat during his play, these activities had been mutually exclusive until then. At first he assigned many tasks to me with the ex-

pressed purpose of keeping me at a safe distance while he played. Later he invited me to watch him and finally, as a sign of confidence, asked me to feed him candy while he pounded. Through elaboration of the functions involved in his conflict in contact with the therapist, they were divested of their threatening and intimidating magic. Through successful testing he gained strength to give up the defensive and isolating mechanization of these functions. In memories and fantasies he dealt freely with his sensations during rectal manipulation. Passive experience was turned into activity when he developed the strategy of confining his father to tight places, and of releasing him after this show of superior strength. Anxiety and concern arose in connection with this fantasy. They were freely and verbally communicated to the therapist and became the motivating force for our reconstructive work, the results of which were anticipated in this report. Communication of material in play, drawing, fantasy and dreams was interspersed with compulsive rituals, grimacing and stereotypes, which now were handled within their meaning as resistances.

A SURVEY OF LEARNING DIFFICULTIES IN CHILDREN

By GERALD H. J. PEARSON, M.D. (Philadelphia)

In the last few years an increasing number of children who have difficulties in learning their school work have been referred to child psychiatrists and child psychoanalysts. This increase in problems of learning may be real or it may be an apparent one. I have been informed that such difficulties were encountered only occasionally in Europe, with the exception of England, so that some of these problems, particularly reading problems, may be inherent in the difficulties in learning to read, write and spell the English language. It is true also that in this part of the United States the school laws compel the attendance of the entire child population up to the age of either sixteen or eighteen years. This means that many children, who are really not capable of higher learning, have to try and their failures may increase the relative high percentage of these difficulties. In recent years psychologists and educators tend to regard the majority, if not all, of the children who seem to have difficulty in learning their school work as suffering from neurotic problems and to refer them to child psychiatrists and to child psychoanalysts.

Whether this increase in the number of cases of learning difficulties is real or is only apparent, because of the reasons I have mentioned, it is true that more and more cases of learning difficulties are being referred to child psychoanalysts. This is a step in the right direction. Liss (1949) states that every child who shows any form of steeple like or valley-like learning patterns requires an evaluation by a psychoanalyst. It is important that those psychoanalysts who specialize in the psychoanalysis of children have a broad knowledge of the factors which may produce such problems and of how they may be cured.

In this paper I have tried to bring together the concepts about these problems which I have formed from a survey of the literature¹ and from

¹For the more important articles on learning difficulties in children, see Bornstein (1930)*, Landauer (1929)*, Bergler (1938)*, Maenchen (1936)*, Liss (1935, 1937, 1940, 1941), Schmideberg (1938), Oberndorf (1939), Fenichel (1945), Klein (1949), A. Freud (1936), and Mahler (1942). I am indebted to Dr. Mahler's paper for the references marked with an asterisk.

my experience with a large number of such cases, to classify the various symptom complexes, to discuss their dynamics and to point out the most useful methods of treatment for them

Essentially a diminished capacity to learn is a problem of ego psychology and therefore I intend to discuss the various factors which hinder the ego in its ability to learn. These factors may occur in the ego itself, as a result of the influences of the external world on the ego or as the result of influences which may emanate from the superego or the id.

I DIMINISHED CAPACITY TO LEARN DUE TO ORGANIC DISORDERS

A Differences in Intelligence

A child may have difficulty in learning because his intellectual endowment is lower than that of the average child. Either as the result of lack of development or of disease or injury to the central nervous system the cortical centers and the association pathways are not as capable of functioning as they are in the healthy child. The causes of intellectual deficiency are so well known to psychiatrists, educators, and psychologists that they do not need to be reviewed here. It is not as well understood that an intellectually defective child labors in contrast to the organic one under an additional difficulty. He is slow in developing and is not able to identify himself with his parents as rapidly and as efficiently as the average child. Therefore his infantile anxieties are prolonged because he has less capacity to deal with them. The constant pressure of anxiety further weakens the development of his ego. His parents also cannot have as much real affection for him as they would for an average child because his defectiveness is a severe blow to their narcissism. In order to avoid the hurt to their narcissism, most parents refuse to recognize that the child is defective intellectually and they try, usually inadvertently, to distort the history of the child's development and may even go so far as to try to convince the psychiatrist that the child is psychotic instead of feeble minded. This lack of parental affection further interferes with the development of the child's ego and with his acquisition of the skills for which he really may have capacity. He contacts the real world, therefore, with an ego, weakened organically and weakened also by a defect in the ability to identify himself and a defect in the amount of love he receives. I have discussed this more fully elsewhere (1942).

Besides generalized intellectual deficiency, individuals differ along certain special lines in their intellectual endowment. Certain people seem to have more artistic, or musical, or mechanical abilities than the average person does and certain people seem to be very deficient in these abilities. It seems probable, although it has not been demonstrated

anatomically, that a part of the reason for these differences lies in specific differences in brain structure, perhaps in the degree of development of certain cortical areas and in the degree of complexity of certain cortical subcortical association pathways. Psychotic children whose illness at present is usually designated as schizophrenia, although there is considerable doubt as to whether the psychopathological process in these children is really the same as in the adult case of schizophrenia, almost invariably show in their infancy a great terror of loud noises or even of any noise. Later these children compensate for this by becoming over-interested in music and usually show remarkable ability. I believe, although this also has not been proven experimentally, that they have hyperacusis because their auditory centers and association pathways are better developed than in the average child. There is definite need for further investigation into this matter particularly as auditory hallucinations are so common in adult psychotics. The probable anatomical differences, however, account only for a partial explanation of the condition, for psychoanalysts are confronted very often with the fact that these abilities are inhibited as a defense against pregenital instinctual drives. Not infrequently after a patient's defenses against his analerotic, sadistic and exhibitionistic drives have been analyzed he will become interested in music or painting or wood-working as a hobby. His performances along these lines, although not perhaps of the caliber by which he could support himself, are very pleasing and creditable. This happens so often that I believe all persons actually have the ability to produce pleasing and creditable results along artistic or mechanical lines but that the ability lies dormant through certain inhibiting effects resulting from the training processes used in early childhood. If these ego defenses, usually of the type of reaction formations, are very rigid, the fear of the expression of the instincts is very great and therefore the ability to produce artistically is below that of the average.

The individual whose ability along artistic, musical or mechanical lines is greater than the average probably has a difference in brain structure but his ability to use this brain structure successfully depends on the degree of inhibition present. It is well known that psychoanalysis of such people increases their ability to improve the excellence of their productions. I believe this to be so even though there is no doubt that "the artist is originally a man who turns from reality because he cannot come to terms with the demands for the remunerations of individual satisfaction as it is first made and who then in fantasy life allows full play to his erotic and ambitious wishes. But he finds a way of return from this world of fantasy back to reality; with his special gifts he molds his fantasies into a new kind of reality. Thus by a certain path he actually be-

comes the hero, king, creator, favorite he desired to be, without pursuing the circuitous path of creating real alterations in the external world' (Freud, 1911)

The ability to learn to read, write and do arithmetic develops as part of a maturational process. At certain ages all children are unable to learn any of these skills. As they grow older this ability becomes manifest. Empirically educators have shown that there is no use in trying to teach a child to learn to read until he is *ready* to do so. This empirical observation is explained usually and probably correctly on the assumption that only when certain associational pathways have become myelinated and therefore useable is the ability to learn to read possible. Again this has not been proven by anatomical studies but the assumption seems to be a correct one. Similarly there must be a time when the child is incapable of learning to write and of learning to do arithmetic, and also there must be a time when through certain anatomical and physiological maturational processes he becomes capable. In some children this maturational process is completed later than in others without any pathology being present. The knowledge of this, however, is very necessary to educators who then will be able to spare the child the secondary emotional conflicts which would arise because he is forced to *try* to read before he is physiologically able to do so. Such conflicts may interfere with the child's ever learning to read. Just as ego defenses against instinctual drives and their derivatives interfere with artistic, musical and mechanical abilities so the same type of intrapsychic conflicts frequently interfere with the ability to learn to read, write and do arithmetic. I will discuss these in detail later.

Children whose total intellectual endowment is very superior may find difficulty in learning in the average educational setup as Terman pointed out long ago.

Case 1 A seven year old girl was referred partly because she was failing in school. On the basis of the child's poor school work her teacher believed she was intellectually retarded. Her IQ was 160. This child's failure was the result of boredom. In fifteen minutes she would be able to understand and master a particular problem which took the rest of the class whose IQ's were average or slightly above about one hour to learn. For three quarters of an hour the patient had nothing to do and in order not to be restless and disturbing spent her time in daydreaming. The daydreams soon became more interesting than was the unsolved problem of the first fifteen minutes and instead of occupying only her unemployed time they began occupying the whole hour. Consequently she learned nothing and at the end of several months her achievements were far less than that of the other members of her class. She also had omitted to learn certain basic fundamentals so that now when confronted by more complex prob-

lems which the rest of the class had the basic skills to solve, she failed utterly. This secondary failure drove her into more intensive daydreaming.

The treatment for both the child whose learning difficulties arise because his intellectual endowment is below average and because it is above average is the concern of the educator. For those below the average specialized teaching methods are necessary. The psychoanalyst can contribute only his knowledge that the ego defects in these children which result from organic pathology are increased by the child's constant exposure to lack of real love in his environment and that it is as necessary to correct this starvation for love as it is to increase his ego skills through education. For those above the average, grading with children of equal intellectual endowment but of the same chronological age is essential.

B Diminished Capacity to Learn Due to Physical Defects or Illnesses

It is a well known fact that children who constantly are fatigued because of lack of sleep, overstimulation and overexertion do not learn as quickly and as effectively as unfatigued children do (I am referring here to cases whose fatigue is not the result of conscious or unconscious emotional conflicts. It has been proven abundantly, particularly during the years of World War II, that abnormal fatigue in adults is most commonly the result of such conflicts. However, the adult does not suffer from the constant expenditure of energy in the simple process of growing as the child does. In the latter, therefore, actual physical causes produce fatigue more readily and more frequently than they do in the former.)

The psychophysiology of the inability to learn in the physically fatigued child is as follows. Steady exercise rushes the venous blood too rapidly through the veins so that it is imperfectly oxygenated. This reduced oxygen tension adversely affects the cortical centers inducing a sense of fatigue and impairs the efficiency of the heart so that the circulation becomes inadequate for the bodily and particularly the cortical needs. The cortex is depressed also by the slight rise in H ion concentration (Wright, 1940).

Even in those cases of children where fatigue results not from excessive physical exertion but from insoluble intrapsychic conflicts and in the cases of adults whose fatigue arises from the latter cause, the physiological basis for the feeling of fatigue and its associated symptomatology is the result of excessive muscular action. Anxiety, the sign of an insoluble intrapsychic conflict, produces tension in the muscles. The degree of muscular stimulation, however, results not in movement but in constant submovement contraction which causes the same circulatory disturbances as I have described above (Fenichel, 1915).

Chronic illnesses, particularly those in which toxic substances are circulating in the blood or as in anemia where the oxygen carrying power of the blood is decreased, result in an impairment of the functions of the cortex and therefore the child with an average or better than average intelligence has an impaired ability to learn

Intellectual, psychic and neurological changes result from vitamin deficiency In certain cases the child's difficulty in learning is the result of chronic avitaminosis—treatment for which improves the learning disability

Vision and hearing are the sensory organs most used in the learning of academic subjects, therefore any defect in them—lens defects partial or total deafness, etc.—will interfere with the child's capacity to learn Often in little children gross defects of this kind pass unnoticed for a number of years This is less common today than it was several years ago, because there has been a steady, desirable indoctrination of the public on this subject However, the effect of slow eye movements on the capacity to learn to read is not as well known Educators are aware that a good reader usually reads rapidly, i.e. his eye movements are rapid, while poor readers often read very slowly as a result of slowness in their eye movements and they need exercises to speed up the rapidity of the eye movements

The ability to learn to write, draw, model and make things i.e., the ability to learn to use the hands in creative ways, may also be disturbed from physical causes Some of these like chronic illnesses, fatigue, avitaminosis, I have mentioned already The effect of gross motor disturbances due to major cortical insults are so obvious that they need only be mentioned However, certain cortical or subcortical lesions involving particularly the cerebellum and the cerebellar association pathways as the result of birth anoxia birth hemorrhage physical trauma or some type of encephalitis may occur These may not be evident on clinical examination but they hurt the capacity to learn the finer uses of the hands and fingers

Case 2 A boy who had a cerebellar insult at birth later was unable to learn to write with any degree of legibility and was very clumsy in doing anything which required small muscle co-ordination

Case 3 Another boy with a similar birth injury showed the same symptoms and also a mild degree of intention tremor toward the completion of a movement such as lifting a glass of water to his lips In both cases the parents and teachers were not aware that the symptoms were the result of the cerebellar insult and tended to become irritated and blame and punish the patients for their stupid sloppiness.

Strephosymbolia with cerebral dominance produces learning difficulties which have special characteristics. Its presence can be ascertained readily through the use of the Orton Monroe Tests (Orton, 1937).

Most of this data is well known to physicians and educators but I have felt it is necessary to reemphasize it because at the present time when there is so much emphasis on the importance of intrapsychic processes in all phases of medicine and education, psychiatrists tend to become overenthusiastic about dynamic intrapsychic processes to the complete neglect of physiological and organic processes, for which they seem to have a psychic blind spot.

The diagnosis and treatment of this group of cases is largely the function of the psychoanalytically trained educator assisted by the psychologist and the physician. Here the psychoanalyst can contribute nothing to therapy but occasionally may be of help in making a diagnosis.

II. DIMINISHED CAPACITY TO LEARN DUE TO IMPROPER OR UNPLEASANT CONDITIONING EXPERIENCES

There are two basic principles of psychic functioning which are often in conflict with each other but which operate in the mind at the same time: first, the pleasure-pain principle with which the human being is born and which continues basically to act throughout the rest of his life. Always basically the human being turns to anything which gives him pleasure and away from anything which gives him pain. The second is the reality principle which is imposed on him through the influence of reality and causes him to subordinate his desire for pleasure and to avoid pain to the limitations imposed by the possibility of real gratification (time and space, real ability, etc.). The reality principle is developed by slow stages during childhood but a great deal of the child's life, particularly before adolescence, is passed under the supremacy of the pleasure principle. There can be, and therefore have been, two methods of utilizing the pleasure-pain principle to encourage the child to learn academic subjects in which, at the time, he has no interest because they mean little or nothing to him.

I. By using his desire for pleasure, he may be bribed with rewards he desires, the gratification of which gives him pleasure, or the subject to be learned may be presented in such an interesting fashion that its learning in itself is accompanied by a feeling of pleasure. The reward which is most gratifying to the child is that of love from the adult, whether this be the parent, or a professional educator. When the child loves the teacher he will do anything to please him—even learn the most uninteresting subject—but he anticipates a real expression of love from the

teacher in return. As long as he gets it he will continue to learn. If he dislikes the teacher for whatever reasons he may have, if the rewards of the teacher's love do not gratify him sufficiently or if the teacher dislikes him, he will refuse to learn even a subject that is somewhat interesting in itself. Educators, as a rule, at the present time, in their theories of education, have a great tendency to discount the validity or the usefulness of this mechanism as a part of learning, although they unconsciously are using it all the time. The more progressive schools are discarding marks, promotions, merit badges, etc., all of which are recognized by the child not as a sign of his achievement, but as a sure indication of the teacher's love. The child who toward the end of the term becomes worried lest he not be promoted to the next grade is not worried about this but is worried lest his teacher and his parents will not reward him with love if he is not promoted.

As one watches children through their years of growth, one is impressed that the motive to learn in order to be rewarded by the teacher's love is a very important and powerful one and continues not only through grade school but also often into senior high school and college. In fact, learning for the sake of learning, i.e., to please the ego ideal of being a learned person, actually is found only in mature people who have really subordinated the pleasure principle to the reality principle.

There will be, then, a certain number of learning difficulties which arise in the following manner. A child enters the room of a teacher whom he dislikes or who dislikes him. If he dislikes the teacher he will not wish to please him because he does not desire the teacher's love. If the teacher dislikes him he will not desire the teacher's love. The teacher may be conscious of his dislike for the child or may be unconscious of it, the end result for the child will be the same. He will have no incentive to learn. If it happens that a new skill is being taught by this teacher the child will not learn its fundamentals. In succeeding years as the learning of more and more complicated processes in the same subject is required, this child is unable to do so or does so very imperfectly no matter how hard he tries. As a result his performance in this subject will never be equal to his abilities, in fact, he may fail completely. Many specific disabilities—reading, arithmetic, foreign languages, algebra, geometry, science—can be traced to this source. The difficulty can be overcome later by tutoring, particularly in the unlearned fundamentals, by a tutor whom the child likes and who likes the child.

It is essential that the subject matter to be taught be presented in a way which is interesting to the child, either because the teacher arouses the child's interest in the subject, i.e., gives the learning of it a pleasure value, or the teacher himself is interested in the subject and the child

through identification takes over the teacher's enthusiasm; he introjects the teacher and his pleasure in the subject. This technique of helping the child to learn is well recognized by all educators, although they may not understand intellectually its psychic basis; that is, the use of the pleasure principle and the mechanism of identification. "Bad" teaching is the common expression for the errors in this situation and has results similar to the result of mutual hostility described above, so that a certain number of learning difficulties arise from this cause. The therapy for such difficulties is tutoring by a tutor who can make the subject interesting.

2. By using his desire to avoid pain. This method has been used for many centuries in the use of punishment, i.e., the infliction of pain, for not learning. Its use is still not uncommon in the more traditional schools. In fact, one of the main differences between the extreme traditional system of education and the extreme progressive one is that the latter depends more on the use of the pleasure principle to induce the child to learn while the former strives to impose the reality principle for a similar purpose, often too completely and too early in the child's life.

If the child does not learn quickly and as completely as the teacher feels he should, he suffers real pain so that he quickly comes to associate not learning with pain. This method often miscarries. The child may associate the teacher with the pain and come rapidly to hate him, then he will not learn. Or he may associate the pain with the subject matter to be learned.

Case 1. A ten-year-old boy did well in all his school subjects except mathematics. In this subject he persistently failed. Careful study of his mathematics revealed that he did all arithmetical processes correctly regardless of their difficulty if the number 3 was excluded. He consistently made errors in the simplest computations whenever the number 3 was included. In the first grade the teacher became provoked with him because of his slowness in learning how to write a 3. She hit him over the hands many times to force him to form it properly. As a result he associated the number 3 with pain and so could not use it in his computations.

This case was never investigated fully enough to exclude without some doubt the possibility that this patient had a phobia for the number 3. Wegrocki (1938) reported the case of a patient who had a phobia for even numbers, particularly 2, 14, and 18. He was indifferent to odd numbers except 21 and 23. He first began to be afraid of the number 2 because it was unlucky and if he did something twice he had to avoid the ill luck by repeating it a third time. The numbers 2, 14, and 18 symbolized certain intrapsychic oedipal conflicts. For example 2 was equated with the idea of a "couple" and with his unconscious sexual feelings for his mother and his desire to be coupled with her. The number 14 was

equated with ideas of his vengeful father on one side and two couples on the other. The 1 in 21 was equated with ideas of his vengeful father of whom he was trying to be rid and the 2 was equated with his longings for his mother. I will refer later incidentally to a similar number phobia in my description of Case 32.

Case 5 A girl of fourteen seemed quite unable to do any problem which required the use of long division. One day during the time when she was being instructed in this process she was kept after school because she had misbehaved. In order to keep her occupied during her period of punishment she was given several long division sums to do. The teacher did not know that the patient had an exaggerated repulsion against using any toilet except that at home. Consequently every day she contained herself and therefore had to hurry home immediately after school to relieve herself. She became more and more uncomfortable as she sat in detention and at last asked the teacher if she might go home but did not state the reason. The teacher refused. The patient's discomfort increased as she struggled with the long division and at last she wet herself—to her intense shame. After this episode the concept of long division was associated with intense feelings of shame and mortification. These unpleasant feelings were so strong that she could not learn long division and even when these feelings were repressed they remained associated in the unconscious with the concept of long division and so this skill could not be learned.

This case is a good example of the results of a conditioning experience. However, it is plain that much that I have described as the results of conditioning experiences actually fall more properly in the field of object relations and so are really part of the next type of learning difficulty.

I believe that cases of diminished capacity to learn because of unpleasant conditioning experiences require treatment by a psychoanalyst. The patient usually is amnesic for these traumatic situations and their effect continues until the whole experience has been released from repression.

III DIMINISHED CAPACITY TO LEARN DUE TO DISTURBED CURRENT OBJECT RELATIONS

The need to learn, i.e., to acquire ego skills and particularly the ego skills of an academic nature arises from a number of sources. One important one is the need to identify himself with the adult. The child envies the power, self-sufficiency and apparent freedom from fear of the adult and desires to be like him so as not to be tormented with feelings of fear, inadequacy, and incapability. The adult also is the source of pleasure, i.e., the gratification of instinctual desires for the child. When the source of pleasure is absent the child becomes apprehensive lest he

suffer pain and discomfort, i.e., he will feel his instinctual desires but will be unable to gratify them. The child believes that if he could become the source of pleasure, i.e., the adult, himself, then he would no longer be apprehensive if the adult were not present because he would never be exposed to feelings of pain and discomfort. In short the child wishes to be the adult in order no longer to feel anxiety, apprehension, or dread. Consciously and unconsciously from the time he becomes aware that his ego is separate from his environment he attempts to identify himself with the adult. This psychic mechanism is one of the most important in the process of education. Among primitive peoples or in cultures where the child readily can observe and understand the fact that the adults' particular activity is directed specifically to a known goal it remains the most important factor in the need to learn ego skills. The small boy in a primitive culture observes his father making a net, taking the net to the water, using it in the water to catch fish, bringing the fish home to make part of the family meal. Through his desire to identify himself with his father he tries to make a net and go through the various phases of fishing he observed, until by repeated efforts he becomes an accomplished fisherman, perhaps much superior to his father. The small boy in the highly skilled Western culture observes that his father goes to his office but what he does there he knows only from hearsay, out of which the boy weaves his own fantasy ideas, which may have little basis in reality. When he starts school he is presented with the fact that he is expected to learn to read, to make mathematical calculations, etc. On the basis of his observations, however, he cannot understand that they constitute an essential part of his father's business life. He has only heard about it but frequently learned that hearsay cannot be trusted. Therefore he does not understand the requirement to learn academic subjects as a part of his need to identify himself with his father. The learning of academic skills in Western culture does not take place through the universal need of the child to identify himself with the father. Instead other motives have to be utilized.

The child of school age wishes to be able to do everything his peers do. If he observes that they are learning to read, their motives being as obscure to him as they are to them, he also wishes to learn to read. Competitive envy is a real intrapsychic motive in learning academic and other ego skills, and it exists in the child even though the adult, parent, or teacher, particularly when the latter is on the staff of a very progressive school, deliberately try to make all learning situations noncompetitive. Real or intrapsychic difficulties about competitive envy may serve as a cause for learning difficulties.

Case 6 In a certain neighborhood there was an unusually strong feeling of gang loyalty among the boys and consequently an unusually strong aversion to the adults. A boy of eight was interested in learning academic skills but he feared to do so and to let anyone know his interest lest his colleagues despise him as a sissy and a teacher's pet.

Case 7. In a particular school several of the first graders refused to learn to read. They were the strongest and the most dominating members of the group. A girl of six, like the boy in Case 6, was interested in learning to read but was afraid to do so because she wished to emulate the dominating party.

In these two cases competitive envy and the fear of the hostility of the group caused the desire to learn to be directed away from academic skills.

I will discuss the intrapsychic disturbances of competitive envy as a motivation for difficulties in learning academic skills later.

In Western culture the teacher stands as the link between the child's wish to identify himself with the parent of the same sex and the use of this identification as a cause for the desire to learn academic skills. As I mentioned earlier, if the child loves the teacher he wants to please him. The best way he knows to please the teacher is to do what he asks, i.e., to be like him. Because he loves the teacher and wants the teacher to love him he identifies himself with the teacher as he did as a younger child with his parents. In making this identification he learns the academic skills which he observes the teacher knows. Of course all of the dynamics in this process go on unconsciously and no one realizes they are there, but they notice the end result.

In the process of identification, characteristics and attributes of the teacher as well as the teacher's ability to read, work mathematical problems, etc., are incorporated to become an integral part of the child's ego. He identifies himself with the teacher because he loves him and expects love in return if he learns, i.e., if he behaves like the teacher. His ego therefore tries to make itself like the loved and admired teacher, i.e., it incorporates him, and when it has accomplished any part of the task successfully the child feels a glow of pride, i.e., an expression of love from the part of the ego which represents the incorporated teacher to the part of the ego which represents the child. The successive incorporations of several admired and loved teachers gradually form a particular part of the ego, the ego ideal, which is partly conscious and partly unconscious. Eventually, perhaps toward the middle or end of high school, perhaps in college, the individual begins to desire to learn for the sake of learning. No longer does he learn to please the teacher but now he learns in order to please and so be loved by his ego ideal. About the same time he begins to perceive that all of his learning of academic subjects,

however remote they have seemed formerly, are all directed toward a identification with, and an attempt to, surpass his father. The child in primitive culture arrives at this goal fairly directly, the child in Western culture only by the detour of identification with the teachers.

As identification with the teacher takes place because the child loves the teacher any emotional reaction of a different nature, such as hate, anger, or fear, will interfere with the identification and therefore with the learning process. No one desires to imitate someone whom they hate, unless such imitation would enable them to attain some desired libidinal goal as happens in the boy's identification with the hated, feared, yet loved father in order to possess the libidinally desired mother. There is no such libidinal prize to be anticipated in identification with the teacher so that the learning of academic skills takes place solely by identification with the loved object. I have already discussed the effect of fear and hate of the teacher on the child's learning process.

The diagnosis and treatment of this group of cases is the function of the psychoanalytically trained school principal and the psychoanalytically trained educator. In the treatment of this group of cases the psychoanalytically trained school counselor can be a valuable person. The psychoanalyst himself has little to contribute except perhaps to help with the diagnosis.

IV. DIMINISHED CAPACITY TO LEARN DUE TO DEFLECTION OF ATTENTION

An important function of the ego is to direct attention to a particular situation or stimulus in order to master it. If the ego is confronted with an external situation which it invests with great importance, the attention is directed toward it and deflected from the multitude of external situations that exist at the same time but which the ego does not then invest with importance. The frontiersman fleeing from the Indians noted constantly the presence or absence of bird songs as an indication of the approach of an enemy but paid little attention to the difference between the songs of various species of birds. The ornithologist traversing the same forests also pays attention to the presence or absence of the songs of birds but his attention will be directed to the specific song of a particular species. In the first instance the presence or absence of bird songs is invested with importance and the attention is directed to that. In the second the song of a particular bird is invested with importance and the attention is directed to that.

In logical thinking the attention is directed to the next logical thought which is invested with importance and is deflected from the

numerous nonlogical associations which are always present but which under these circumstances are not invested with importance. In the free-association technique of psychoanalysis exactly the opposite is required. All associations, no matter how apparently illogical, are invested with equal importance and the attention is directed to them.

The ego also directs its attention to the instinct representations arising from the id. At one time a particular one is invested with importance and attention is paid to it and deflected from all other instinct representations.

The deflection of attention calls into play many other psychic mechanisms of defense, in order to assist the ego function of centering attention. The process of attention is usually unconscious, although occasionally its presence as a conscious effort may be perceived.

In childhood, particularly prelatency, the defensive functions of the ego are relatively weak in the presence of instinct representations and therefore the ability to center attention is less than in later years. The child is distractible. His attention is easily distracted from one instinct representation and from one stream of thought and from one external situation to another. Children of the latency period, adolescents and adults are less distractible. The degree of distractibility depends on the strength of the instinct representations and on the strength of the ego's defensive measures, i.e., on the relative strength of the defensive functions of the ego. When instinctual drives for whatever reasons become unusually strong the individual becomes distractible. When one instinctual drive for whatever reason becomes unusually strong the individual becomes indistractable. His attention is centered upon the particular drive. When no particular external situation or train of thought is invested with importance, the individual appears to be distractible. His attention is readily distracted from one situation to another and he seems to have no particular *interest* at that time. When a particular external situation or train of thought is invested with great importance i.e., when the person is deeply interested in it, he often cannot be distracted from it. As I write this the radio is playing and there are many pleasant sights surrounding me but my attention is not distracted by them. Many adults and adolescents and a number of children in the latency period can work well and with interest on a particular intellectual problem with the radio playing. Their accomplishments are not less than if it were silent. Such people are not distracted by the sound of the radio.

The usual procedure in Western culture of starting a child in school at about the age of six is based on an unconscious recognition by educators that the child before this time is too preoccupied with, i.e., has his attention too centered on, the intrapsychic conflicts occurring during

the oedipus situation to be able to center it at the same time on the process of acquiring academic knowledge.

I am still not certain as to whether such phenomena as reading readiness, etc., really are the results of maturation of myelinization of the cortical association traits. More careful investigation may show that they result from the lessening of the child's intrapsychic conflict with the solution of the oedipus conflict and the consequent beginning of the latency period.

Educators tell me that it is common for a child who has been quite successful in scholastic achievement during his grammar school life to begin to develop difficulties in learning about the 7th grade. These difficulties continue for about a year or longer and then disappear. The increase of sexual desires at puberty reinstates the intrapsychic conflicts of the oedipus period and the child's attention becomes centered on these conflicts and therefore directed away from the subjects to be learned.

The distractibility of a particular child is usually considered to be due to either the strength of instinct representations or to the developmental weakness of the ego's function in centering attention. This is probably a correct assumption on which to proceed, but it is possible that certain people congenitally are predisposed to distractibility. Further studies on this specific point will be required before this possibility can be eliminated. Centering of attention on the academic subjects to be learned and the inhibition of deflection of the attention to other internal or external situations is a necessary mechanism for a successful learning process. Conscious worries attract the person's attention and therefore prevent his centering his attention on the subject to be learned.

Case 8. A young man deeply worried about his health was unable to eat, had no sexual desires for his wife and at the particular time did poorly at his job. His worry about his health attracted all his attention and deflected it from all other intrapsychic or external constellations.

Intrapsychic conflicts—whether perceived consciously as worries, feelings of guilt, shame and embarrassment, or as daydreams, or whether occurring in the unconscious portions of the ego—attract the attention to themselves and deflect it to a greater or less extent from all other external or intrapsychic constellations. These "worries" may be classified into several groups.

A. Engrossing Conscious Apprehensions of Dangers to the Child's Security

Case 9. A boy of ten could hardly bear to remain a full day in school. Usually he ran home after a short period of classes. During the time he was in

school he could pay no attention to what was being taught. His parents quarreled constantly and his mother, to whom he was much attached threatened verbally almost every day to pack up and leave the family. He really never knew when he left the house in the morning whether he would find her at home when he returned. When he sat in school he worried lest she had left already and so when the worry became unbearable he ran home to assure himself she was still there. In itself the situation at home was sufficient to cause the patient a great deal of real worry but he also had an intrapsychic conflict which was joined to the real situation.

Case 10 A fourteen year old girl in the middle of an important examination suddenly became panic stricken with the thought that her father had killed her mother. Her hand became useless so she could no longer write her paper and she was forced to go home immediately to assure herself the murder had not taken place. The thought that her father had killed her mother arose from two sources. Her parents quarreled violently and frequently. Her father threatened to kill the mother and often actually attacked her so there was the real worry that when she was away murder actually might be committed her mother would be dead and her father either a prisoner or a fugitive from justice. She had very ambivalent feelings to her mother. Consciously she seemed to take her mother's side as appears in the conscious reason for the school episode. Unconsciously she hated her mother and wished she could kill her but felt very guilty about this wish hence the paralyzed right hand. In this case a real situation which caused real worry was accentuated by the intrapsychic conflict between her feelings of hatred for her mother and her feelings of guilt about this hatred.

In both cases the patient's attention was centered on the real situation with great apprehension of what really might happen to them in their living situation. It was centered also on the intrapsychic conflict and therefore could not be centered on learning academic subjects.

B Engrossing Conscious Feelings of Guilt, Shame and Embarrassment as the Sign of Fear of Real Detection and Punishment or of Superego Disapproval

Case 11 A boy of thirteen was deeply in love with a girl in his classroom. The love affair was a fantasy one as is usual at this age and he expressed his feelings only very occasionally and in private to the girl who only reciprocated slightly. He did express his feelings of love through writing verse which he never showed to her or to anyone. One day a friend of his found the book in which he kept his poetry and read a verse or two aloud mockingly. The author became overwhelmed with shame and embarrassment and was for several days tormented by these feelings to such a degree that he was unable to do any of his school work. Before his friend's betrayal the boy had been constantly reproved by his superego for his feelings of heterosexual love but the strength of the love caused him to attempt to ignore the reproof. His friend's ridicule reinforced the superego reproof and the combination of dread of further external ridicule

and of dread of ridicule from his superego centered his attention on his feelings of shame in order to activate his defense against his instinctual desires. The focusing of his attention on his feelings of shame deflected it from his learning tasks

Case 12 A boy of ten had been stealing. He felt very guilty about his actions but the feeling of guilt did not stop his stealing which was continued because it was a distorted expression of certain unconscious instinctual desires and therefore drew strength from his instincts. He also became afraid he would be detected and punished. The fear of detection was an attempt on the part of the superego through projection to reinforce its prohibition against the strength of the instinctual drive in a manner similar to the mechanisms in Case 11. This increase in the strength of the superego prohibitions focused the ego's attention on the feeling of guilt and deflected it from the task of learning his school work, which suffered badly during this period of worry.

During the latency period and early adolescence the attention is focused on feelings which indicate the presence of superego prohibitions usually when the prohibitions are directed against sexual drives as in Case 11. The focusing of attention on superego manifestations is usually quite marked and the consequent deflection of attention from the task of learning is indicated by a quite serious although perhaps short lived, decrease in academic achievement. It is unfortunate that these deflections of attention, from whatever cause, result in the child's not learning the particular sections of the subjects being taught at the time the attention is deflected. The results of this lack of learning, however short lived it may be, show consistently in difficulties in mastering later aspects of the same subjects and the individual may labor under inadequate skills in these subjects for the rest of his life unless he receives special tutoring in the parts he did not learn. It is the duty of the educator to see that this special tutoring is provided in all these cases after the conflict has been solved. This is seldom done at the present time unless the learning loss has been tremendous but here the intrapsychic conflict is usually deeper seated and more serious than in the cases I have been discussing.

C Engrossing Conscious Feelings of Horror and Fear

Case 13 A girl of twelve began to fail in her school work. Shortly before the failure began she had been told by her friend about the phenomena of child birth—the friend depicting vividly and with much exaggeration the painfulness and bloodiness of labor. The patient formerly had been quite satisfied with her feminine role and was looking forward with eager anticipation to the time when she could be married and have many children. Now these desires and anticipations became terrifying. In order to integrate these two incompatible ideas she had to focus her whole attention on this conscious conflict so that she was unable to attend to her academic work.

Case 14 A boy of fifteen began to fail rather suddenly in his school work. He lived in an unsupervised home and had been having regular intercourse with his sister, a year younger. About this incestuous relation he apparently had no feelings of guilt. However, as his sister approached her fourteenth year, he became frightened lest she become pregnant. He had no knowledge of contraception and was in conflict between his desire to continue his sexual gratification and his fear of impregnating her with the consequent detection and scandal. His attention was focused on this conflict and so was withdrawn from his task of learning. Here the conflict was between two different ideas in his ego and as in the last case the attention was focused on it in order to reinforce the ego's synthetic function.

D Engrossing Conscious Involvement with Instinctual Desires

Case 15 A girl of fourteen rather suddenly began to fail in her school work. At this time she had become aware of a strong desire to masturbate, to which she succumbed at intervals. After each time, however, she experienced great remorse and fear, so great that she preferred to walk the floor all night lest by getting into bed and trying to go to sleep she might succumb again. Of course the fatigue on the next day interfered with her ability to learn. Her attention was focused night and day on the problem of whether she would masturbate or not and so deflected from her task of learning. In this case the conflict was due to the strength of her instinctual desires and their demands for gratification. These desires were opposed by her ego fears with regard to the results of the act and by her feeling derived from superego prohibitions against the unconscious fantasies during masturbation, that masturbation morally was wrong.

The manner in which the strength of an instinctual impulse focuses attention on its need for gratification and therefore interferes with other ego functions, such as judgment, besides deflecting attention from other tasks at hand, is well illustrated by the following case.

Case 16 A boy of eight was under treatment for enuresis. One of his psychological problems was his defenses against anger. In one treatment hour he made a request which I had to refuse, pointing out to him the reality reasons for the refusal. At the same time I tried to ascertain what the motivations in the request were. I could not find these out at this time because he changed the subject. He accepted the refusal in a reasonable manner, although I knew he was very angry but was unconscious of that anger. He immediately desired to make a boat out of wood and asked for hammer and nails, an expression of aggression. Heretofore he could make things as well as the skills of his age would permit. Now he failed completely. He selected nails of a size impossible to use, which he would never have done formerly. He selected pieces of wood which could not possibly be combined to form anything like a boat. He pounded the nails in an exceedingly unskillful manner and the end product had not the least resemblance to a boat. All of these actions were in marked contrast to what he had been able to do at other times. He was attempting to sublimate his unconscious anger and